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SENILITY.

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There are few if any subjects in the medical literature of the same degree of concern to the general practician, to which so little has been contributed as to the subject of Senility. In view of this fact I present for your consideration a paper on this subject, not for the purpose of adding new material to its literature, but hoping to elicit a discussion, and my paper shall have accomplished the purpose for which it is intended.

The need of a more thorough understanding of this subject is obvious when we consider the large percentage of cases which come under our observation and treatment for the infirmities of old age, and that out of this class of sufferers only about half ever call into requisition the services of a physican, because of their contention that they have reached the period of life, the condition of which is beyond human power to modify, and a destiny we all must meet sooner or later unless our lives are terminated by disease or accident. This contention that old age is not a disease prevails in the majority of physicians as well as in the minds of the laity. This popular belief is impressed upon the developing minds of childhood until it is accepted as an established fact, and consequently we neglect to do all within our power to mitigate the sufferings of old age, or to in any way retard its advent. There are other factors which are to a great measure responsible for our manifest neglect and indifference with reference to the treatment of the infirmities

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of old age. Of these I shall mention only two: First, the low estimated value of the ineptitude to material prosperity; and, Second, the disturbing element they become in society.

We as physicians can not hope to eliminate these factors in the causation of the retarded progress of the treatment of senility, but it is expected of us that we apply ourselves to the extreme limitation of our possibilities to give the decrepitude the same quality of service that we would give to those who occupy more important places in material development and in social functions.

I shall now endeavor to portray the condition of body and mind resulting from the degenerative changes characteristic of old age.

The beginning of the period of old age from the biological point of view, is at the time of cessation or decline of the reproductive function. This occurs suddenly in women at the time of the menopause, while in men there is a gradual decline from about the fiftieth year. During this period the body undergoes certain degenerative changes resulting in the gradual loss of function in the various organs.

It seems to be the consensus of opinion that the most important and characteristic of the senile changes are those that occur in the walls of the blood-vessels, especially the arteries Arteri-sclerosos. In regard to this disease Osler says, "Longevity is a vascular quesand has been well expressed in the axiom that a man is only as old as his arterties."

We always find associated with old age some form of vascular degeneration, namely: atheroma, followed by calcification which is usually found in the aorta and its branches, or sclerosis or cardiac hypertrophy, or a combination of several or all.

The connective tissue of the walls of the blood-vessels is increased in quantity. This produces a contraction by pressure on the blood-vessels supplying the artery, thus cutting off its supply of nutriment, which in turn causes weakening and degeneration of the walls of the vessel. This increased amount of connective tissue also leads to obstruction or obliteration of the vessels.

The degenerative processes of the walls of the vessel favors a precipitation of calcareous matter causing the vessel to lose its elasticity and contractility becoming hard, rigid and brittle, hence easily ruptured.

The heart is one of the organs most frequently impaired in old age. Its force is wasted against the rigid walls of the arteries causing an hypertrophy of the left ventricle, and when the coronory arteries are involved in the degenerative processes-alterations in the myocardium or myocarditis.

The result of this condition of the vascular system is evident. We all agree that health and continuancy of life primarily depend on the provision through the blood of sufficient nutriment of proper character for all the tissues and organs of the body, and that deficiency in either quantity or quality will result in derangement of function, and ultimately in alterations in structure. Accordingly, we find in the skin of the aged a diminished supply of nutritive fluids, and an impervious nature of the vessel walls, resulting in atrophy of the subcutaneous tissue, with wrinkles in evidence; a diminished amount of secretions hence a dry skin, and deficiency of pigment—gray hair; and general atrophic changes resulting in loss of hair. There is also a loss of warmth, softness and pliability, and a tendency to malignant and other morbid proliferations.

The impairment of vision depending on opacity of the crystaline lens so common in old age can be ascribed to diminished vascular supply to the anterior region of the globe, or to interference with the osmotic action of the nutritive fluids.

The degenerative changes in the brain result in a decline of its functions; the reflexes become slower, and less intense; the organs of special sense become impaired. The hard, brittle and unyielding arteries cause a predisposition to hemorrhages with a variety of symptoms such as monoplegia, hemiplegia, aphasia, vertigo, etc.

The organs of respiration in old age are all enfeebled; the sternal segments become ankylosed; the costal cartilages become ossified; the ribs change somewhat in shape with a resulting loss of mobility and capacity of the chest and a predisposition to bronchitis, pneumonia, emphysema and hypostatic congestion.

Atrophy and degeneration of the glands of the digestive tract with diminished secretion is also to be found, as well as loss of tone of the muscular fibers of the stomach and of the intestines, allowing them of dilatation. This is particularly noticeable in the colon of man, which is a favorable harboring place for a multitude of disease germs and toxins.

Senile atrophy of the kidneys, "interstitial nephritis" results from the vascular derangement of these organs with diminished secretion and retardation in the removal of waste products from the body.

Prostatic hypertrophy so common in old men is an increased amount of connective tissue with the resulting atrophy of the glandular structures. This in turn affects the bladder by interfering with the flow of urine; the bladder being distended diminishes the power of contractility of its muscular walls resulting in chronic cystitis.

There is a lessened one of the muscles generally throughout the body, and a general fragility of the bones, and a tendency towards calcification of the cartilages, and ankylosis of the joints and structures.

I have enumerated the most important of the symptoms or manifestations of senility. Before entering upon a discussion of its causation, I shall divide it into two classes, viz: 1st, Pathological Senility, characterized by a condition of retrograde changes caused by the action of external agents or forces, and 2nd, Physiological Senility, characterized by a condition of retrograde changes resulting from some inherent defect or deficiency of the cells.

It is the first class pathological or premature senility, which is of greatest concern to us. The most prominent causes of this class of senility are: excessive muscular and mental activity, infections from fermentation or putrifaction from the alimentary canal, metalic and bacterial poisons, syphilis and alcohol.

To the first of these named causes we can apply the theory of compensatory endarteritis, and according to Thomas' law every slowing of the blood current in the arteries and veins of man which is not completely and at once remedied by a proportionate contraction of the media leads to a new growth of connective tissue in the intima which narrows the lumen of the affected vessel and thus restores the normal swiftness of the blood current more or less completely, and vice versa whenever the intima is unduly stretched from overexertion, the connective tissue tends to increase giving rise to a compensatory endarteritis. The infections from the fermentation and putrifaction in the alimentary canal, are in my judgement responsible for the majority of cases of premature senility. I shall assume that these infections of pathogenic organisms and toxins as they are found circulating in the blood current have an irritating effect upon the cells, causing inflammations with a resulting destruction of the specific cells, which are replaced by connective tissue cells, which of course are unable to perform the function of the cells which they replaced.

The metallic poisons, syphilis and alcohol disturb nutrition.

The causation of physiological senility remains in obscurity. That there is a deficiency or defect in the cell of an individual of advanced years. we cannot deny, but, what is this deficiency or defect of the cell? This is a problem the solution of which will require much effort in time to come by both the microscopist and the chemist. As yet the microscope has not shown any structural difference in the young and the old cell. Neither has chemical analysis revealed any difference in composition of the juvenile and

senile cells. It is in their biologic functions and properties that we detect their dissimilarity. It is a fact that in man after the fourth or fifth decade there is a manifest depreciation of the cells, such as nutritive failure, loss of regenerative power, and diminished resistance to bacteria and toxins. This innate depreciation of the cells ensues independent of any of the recognized external causes, and if not affected by them the delectable period of life will gradually fade into a state of physiological degeneration.

It is obvious then, that it is our duty to combat the deleterious influences that cause a departure from the normal tendency to retrogression, and to restore functional activity.

By keeping in mind the presence of perverted metabolism; the field of physiological activity is becoming progressively limited, while the dissimilative process increase is of inestimable value in outlining a course of treatment.

In conclusion I shall merely make mention of what I consider the most essential features in the management of premature senility.

Nutrition must be improved, and one of the first things for us to do with the majority of cases is to refer them to the dentist, inasmuch as digestion cannot go on to any appreciable degree of perfection when food is swallowed without being masticated and insalvitated.

The dentists are certainly contributing a great deal to comfort, good health and longevity.

The diet should be selected to meet the requirements of each individual case.

In consequence of the functional insufficiency of all the organs of elimination, we have an accumulation of excrementatious matter in the system which, for the sake of good health, must be removed. This can best be accomplished by frequent bathing; massage of the skin; moderate exercise in the open air; drinking an abundance of water, and keeping the bowels active by the daily administration of magnesia or any of the mineral waters—Abilena or Carabana—also colonic flushing. Deep abdominal massage is also serviceable in restoring the proper tone to the relaxed bowels.

The indications for drugs in these cases are usually well defined. The two most frequently in demand are digitalis and potasium iodide.

I predict that the time is not distant, when the medical literature will contain glaring reports of the use of some anti-senile serum that will supply the cells with properties which will materially aid them in their metabolic, bacteriolitic and anti-toxic functions and thus restore pathological to physiological senility.

DISCUSSION.

Dr. Sheldon:—The statement that the doctor made in the beginning that there is very little written on this subject is very true in ordinary medical writing. If we go outside of medical work, there is more to be obtained. Several men have taken up the scientific study of old age and death. These investigators have shown the similarity of the changes of old age in man to that occuring in animals, plants and in the lowest forms of life. Even the preconjugal debility of the infusoria has been shown to correspond with the senile changes of man.

Now, as Dr. Nordstrum has stated, the predominating anatomical change in senility is an increase in the connective tissue elements of the body. The parenchymatous organs, the frame work of the body, and even the nervous system show an abnormal increase in connective tissue in old age.

The primary or underlying cause of the excessive proliferation of connective tissue that occurs in senility has been a much studied subject. Merkel, in 1890, in a paper read before the International Congress of Medicine at Berlin, claimed that the normal connective tissue of the body was to be held responsible for the fibrosis of old age; and, that the primary change in senility was connective tissue proliferation which resulted in destruction of the epithelia structures of the organism. Later, and more elaborate investigations, especially those of Metchnikoff, have shown conclusively that the connective tissue proliferation of senility is secondary to degeneration of the epithelial structures of the body, and that these epithelial cells are destroyed by large leuokocytes called macrophags. The primary observation which resulted in bringing out this theory was made while attempting to determine the cause of gray hair. It was found that in the central canal of the hair, cells took up the pigment and then migrated from the hair, leaving it without pigment and of course without color. This key to the changes in senility made it possible to confirm or disprove the leuokocyte theory by examinations of other portions of the body. Senile changes in the parenchymatous organs, the bones, the arteries and the nervous system, coincide with Metchnikoff's theory. For a time those whose observations were limited to the nervous system refused to accept this theory. Among these observers was Marinesco, who sent his specimens for examination. It was found that the leuokocyte change was slight in the peripheral nerves and cord, while in the same subject, the cortex of the brain showed very plainly the action of the macrophags. All osbervations have confirmed Metchnikoff's views, and have shown that the changes of senility are more marked in certain portions of the body than in others. The vascular system is particularly affected. Dr. Nordstrom has called attention to this important observation and has reminded us of Cazalis' statement that "man is as old as his arteries." Clinically, the condition of the vascular system is of importance, for it is a quite reliable index of the patient's reserve force. Now, since we understand fairly well the minute, as well as the gross changes, occuring in old age, the next question that presents itself is: What forces or conditions are responsible for this undue activity of the macrophags in the aged? We do not know. The answer turns us back to the law that the inevitable termination of life, in both animals and plants, is practically death. While this law is perhaps no more true today than it has been in the past, it seems that the life of man has been shortened; that instead of living one hundred or more

years, we live but 70. This suggests that there has been brought about a premature senility that is in a sense pathological. What are the causes of this premature senility? I shall mention two of them: modern civilization and the large intestine. Although man is comparatively a recent arrival on this earth, he has made great progress in the last few centuries. Human art has, in many instances, been able to surpass nature; while modern methods of nourishment and shelter are superior to those of our ancestors, nature has attempted to keep abreast with our artificial methods but it has been unable to do so, and the result has been a number of physiological disharmonies which progress until they become pathological, produce a permature senility and shorten life. Civilization has added to our comforts and pleasures at the expense of our years. There is abundant evidence of the disharmonies in the constitution of man in human and comparative anatomy. The wisdom teeth, the jaws, the lower or grinding portion of the stomach, the appendix and cecum, are today rapidly undergoing atrophy for the reason that nature has either altered or abolished their functions. The large intestine is frequently to be held repsonsible for premature senility. In the large bowel, stagnation results in the formation of poisonous chemical compounds which are absorbed and are repsonsible for the changes that result in the degeneration of epithelial tissue and its destruction by microphags, and the subsequent connective tissue proliferation—the characteristic changes of senility. The large intestine in man has become an unnecessary organ. It is possible that in previous centuries it functionated by digesting cellulose and assisting in absorption; and, it may be that today it is a necessary organ in horses, cattle, rabbits and some other animals, but in man it is only an organ of convenience acting as a receptacle, as does the urinary bladder. It constantly contains products of fermentation, some of which are poisonous. The advantages of having a colon in no way compensate for the disadvantages. In animals, the presence or absence of a large intestine bear a direct relationship to the duration of life. Birds which live in the air, so to speak, and therefore do not require a large intestine for a receptacle are not provided with a large bowel. They are long-lived. While birds that do not fly, have a large intestine, and their lives are of brief duration. The crow, parrot, swan and other flying birds are long-lived; while the ostrich lives only 35 years—a very much shorter time. Is the large intestine responsible for this marked difference? In animals, reptiles and birds the length of life bears a definite relation to the presence or absence of a large intestine. * * * * * (Time called. Motion carried to go on.) * * * * Now, if I say anything more, I shall have to talk of the pathology of senility and summarize it in a very few words. We see today that we apparently have an increase in appendicitis and an increase in carcinoma. We see that these peculiar diseases involve certain organs and are found in certain locations. We cannot explain it on any chemical or bacteriological basis. We see that ulcer of the stomach, in almost every case, occurs in the lower part of the stomach. Why? Now, going back to physiology, you will see that the lower portion is a grinding organ purely and simply. It has been used in previous generations to grind up food. We do not use it any more; consequently, the muscular layer is undergoing atrophy from disuse, while the fundus of the stomach is still active and not often the seat of disease. This might be the underlying explanation. We know that the glands in the lower end of the stomach are of little value and that the lower portion of the organ is wasting; but, we fail to recognize the connection between

atrophy of the stomach, and carcinoma and ulceration. In the human teeth we have an example of the disharmony between civilization and nature. Our ancestors had unnecessary teeth, and our wisdom teeth are disappearing. They are absent in 10 per cent of Europeans; and, those of the upper jaw are absent in 18 to 20 per cent of the so-called highly civilized individuals. They appear late in the development and are imperfectly formed. All of these things explain why the wisdom teeth are often causing trouble. There is no useful function of these teeth to offset their disadvantages; and, it is probable that in time, nature will complete the process of their elimination. The vermiform appendix is another rudimentary organ that today serves no useful purpose. It is of low resistance for the same reasons that apply to the wisdom teeth; and, on account of its anatomical location, is causing a great deal of trouble. It is probable that this organ, together with the cecum, has been necessary sometime in the past; but, today appendicitis stands as an example of a disease made possible because we have artificially rendered a portion of our anatomy easy prey for one class of our natural enemies—pathogenic bacteria. The cecum is not so detrimental as the appendix, but it is unnecessary for our maintaining a physiological balance. It is of interest in comparing man with the lower animals—for the cecum in certain animals, particularly the rabbit, is a useful organ. The entire large intestine, like the appendix and the cecum, has not only become an unnecessary organ, but a harmful one. We no longer need it to digest cellulose, while its power of absorption is secondary and superfluous. The size of our large bowel is out of proportion with the quantity and quality of our food. It is too large. This disharmony results in constipation, stagnation, undue fermentation, auto-intoxication and premature senility. Our digestive disharmonies and our short life, with the instinct to live, and the fear of death, constitute the greatest disharmony in the constitution of man. What remedies are to be suggested to harmonize these disharmonies—to prevent premature senility and prolong life? We cannot turn back to the methods of our remote ancestors. The vegetable diet does not solve the problem. We are operating for appendiictis, carcinoma and ulceration of the stomach; we are doing something to relieve suffering and prolong life; but, we are not diminishing the frequency of occurrence of these diseases. Surgery might go one step farther and short circuit the large intestine by implanting the ileum into the sigmoid flexure. This would prevent constipation and undue stagnation, and to some extent, fermentation and auto-intoxication. To my knowledge, three of these operations have been performed with gratifying results; and, in the not distant future, this operation may become a recognized surgical procedure.

Dr. Nordstrom:—It is too late now to say very much. I appreciate highly what has been said by Dr. Sheldon.

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SOME ESSENTIAL POINTS IN THE DIAGNOSIS OF NERVOUS DISEASES—WITH REPORT OF CASE.

By Dr. O. D. Walker. Salina, Kas.

The title of this paper at once suggests that it is not exhaustive; there is not the time, nor would this be the proper place to take up in detail the many essential points in the diagnosis of nervous diseases.

In studying a given case of nervous trouble we need, as a rule, to be more particular in following an orderly outline than in any other form of disease. Hence, the family and personal history, alcoholism and syphilis are to be especially noted. Motor and sensory disorders both general and special; electrical reactions, present conditions, reflexes whether exaggerated, lessened or abolished, symptoms both subjective and objective, swaying of the body, while the gait, whether ataxic, spastic or that of simple weakness, all furnish valuable data essential to correct diagnosis. In this paper, however, I shall confine myself to a few points touching organic and structural diseases of the brain, cord, and peripheral nerves. Functional and nutritional diseases must be passed for lack of time.

The researches of physiology and pathology have done much in advancing our knowledge in all branches of medical science, and certainly this is true in nervous diseases. The same form of pathological lesions will be found in nervous structure as obtains in other tissues.

In no class of diseases is an intimate knowledge of the anatomy and physiology of the structures involved so essential to a correct diagnosis as in those affecting the nervous system, and especially is this true of organic and structural diseases of the brain cord and nerves; but with this precise knowledge in anatomy and physiology a definiteness can often be reached in nervous diseases not possible elsewhere.

A large per cent of general practitioners fail utterly to make a differential diagnosis between the various forms of paralysis. A flaccid or spastic condition means nothing, a lost, lessened, or exaggerated reflex suggests no location of lesion. He may observe that in one case of paralysis there is atrophy with vaso-motor changes, while in another atrophy is not noticeable, but it is all

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the same to him so far as having a definite idea as to the part of the nervous system involved. This comes about, not from lack of interest in nervous diseases, nor yet from a want of a comprehensive view of medicine in a general way, but rather from a lack of knowledge of the anatomy and physiology of the nervous system. And, this knowledge cannot be attained in the ordinary superficial way in which much medical study is carried on, but only by careful, persistent application, so it comes about that many nervous affections are treated upon general principles with but little satisfaction to the doctor and small benefit, if not actual injury, to the patient.

In the spinal cord we find thirty-one segments, piled one on top the other, each segment having a pair of spinal nerves and each possessing a motor, vaso-motor, trophic and reflex center. Going out from each of these centers, located in the anterior horns of the cord, we have the lower neuron which carries the efferent impulses to the periphery and also contain the trophic and reflex fibers, if indeed we have separate fibers for each of these. The afferent or sensory fiber from the periphery to the cord, completes by its connection with the neuron of the efferent fiber, the reflex arc which must be unbroken in order to get any reflex whatsoever to the part. With this reflex arc complete and a normal muscular tissue, we will have the cord acting as a reflex center and with inhibition from the cerebrum intact, we have a normal reflex, while with inhibition cut off by disease in the brain or the motor pathway through the cord, we have exaggerated reflexes. With disease involving the anterior horns of the cord, thereby destroying the nutritional center of the lower neuron, as in poliomyelitis, we have a break in the reflex arc between the cord and the periphery: also a disturbance of the trophic and motor centers and we get lost reflexes, flaccid paralysis and rapid atrophy.

One must have a correct understanding with reference to the brain blood supply in order to properly appreciate and diagnose those focal diseases of the brain dependent upon arterial disease. When we know that the branches given off from the great basal arteries after entering the brain stem, do not anastomose, but are terminal in character and are distributed to a portion of brain tissue represented by a pyramid with its base toward the median line, from base to vertex, and further that the danger from hemorrhage will be found principally along the track of these branches passing up from the basal arteries and distributed especially to the lenticular

and candate neuclei and internal capsule, a small clot along this pathway involving, as is frequently the case, all the fibers from the motor area of one side; by understanding these points we would scarcely be led into trephining over the entire motor area, as I have known to be done, for the removal of a supposed cortical clot when the case gave no history of traumatism, but rather one of undoubted syphilitic infection and the lesion had happened several months previous to the surgical procedure.

The brain is also the great psycho-motor and sensory center; it is the cortex which receives and registers afferent impressions and from which are sent out the voluntary efferent impulses. This gives us, so far as the motor fiber is concerned, a neuron in the cortex and its neuraxon which is projected down the cord ending by arborization or contiguity about the lower neuron in the anterior horns of the cord: this, we term the upper neuron, and so far as nutrition is concerned, is separate and distinct from the lower neuron.

The brain, too, must be looked upon as the inhibitory center, as it is also the center for the higher psychical functions. This inhibitory influence controls the reflexes and follows the motor pathway through the cord, through the crossed pyramidal tracts.

Keeping this in mind, we readily see why in diseases affecting the brain along the cortical motor pathway and also the diseases of the cord, involving the crossed pyramidil tracts, we have lost inhibition and consequent exaggerated reflexes and accompanying this state of reflexes a spastic condition.

Our knowledge of cortical localization is not by any means perfect, only within the past year or so there has been a revision of opinion regarding the motor area and now instead of the motor area being on both sides of the fissure of Rolando, particularly in the ascending parietal, it is now believed to lie anterior to Rolando in the ascending frontal convolution.

The cortical centers concerned in speech are the Visula, Auditory, Receptive and emissive speech centers, the noun or naming center and motor graphic center. Without taking up time to locate or describe each of these cortical areas, I will speak of but one: The noun, or naming center, believed to be located in the third temporal convolution of the left brain, except in case of left handed people, when it will be found upon the right side. As the name of this center indicates, this is where the names of objects, both common and proper, are registered and memorized.

A very interesting case illustrating this center fell into my hands several years ago which I will now proceed to report: J. H. presented himself for examination. He was in good physical condition, complained of nothing special except the loss of memory for names of people, places and objects, which loss he said had existed since the injury. The history of the case was that a few months previous in an altercation he was struck upon the left side of the head with a brick; was rendered unconscious, picked up and carried to a doctor's office where it was found that he had sustained a fracture of the skull over the left temporal region. An operation was performed in which the fractured skull was moulded back into place as well as possible and a few small, loose pieces of the bone removed. The man made an uninterrupted recovery so far as the wound was concerned. Upon examination I found a linear scar running in an anterior-posterior direction just above the left ear, the lobe of the ear having to be depressed to see the scar. The man was strong and healthy looking. Further examination showed no paralysis or sensory disturbances; no defect of word hearing, word sight, motor agraphic, motor or conduction of speech. His articulation was good, speech fluent, no misplacing of words, but whenever in his conversation he had occasion to use a common or proper noun he would hesitate, and after considerable effort to recall the name he would give it up. He could not recall the name of anyone of his immediate family just after the accident, but three months later when I saw him he knew the names of some half dozen people with whom he had been in daily contact. These names he had memorized by constant use, and perhaps the right brain had been educated to this extent.

A common object, as a pencil, knife or key, he knew the use of but could not name the object, but recognized the name when correctly called. He also knew the use of an object or instrument. A pencil he knew was to write with. On being shown a knife he said, "I can't call the name, but I know it is to cut with." "A key," he said, "was to unlock a ——." Here he would stop, not being able to call the name "door."

I tested him with names of towns along the river with which he had been very familiar for years, and found his memory for names entirely gone. Right here I must stop with this most interesting case. I got a promise from him to return to the hospital for an operation one week later, when I expected to open up over the site of the traumatism, feeling certain that I would find some-

thing, maybe a depressed bone, perhaps a spiculae of bone driven into the brain, or a blood clot making pressure over the cortex at this point, and the removal of which might again allow the cortex to functionate. His failure to return and removal from the city defeated my purpose. The location of this injury was directly over, or external to the third temporal convolution. I have since felt that here was a case that might have added something of knowledge to our fund of cerebral localization.

In this paper I have attempted to state some of the essential points in the diagnosis of nervous diseases; points which to me have been helpful. There are many more not touched upon, but what I have tried to say here will obtain also upon other points not mentioned, and that is, that the differential diagnosis of nervous troubles require a more precise knowledge of the normal anatomy and physiology of the nervous system than is necessary in any other class of diseases.

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The following articles will be added to the list of new and non-official remedies approved by the Council on Pharmacy and Chemistry: Taka-Diastase (Parke, Davis & Co.,) Colalin Laxative (Rufus Crowell & Co.,)Maltzyme Plain (Malt-Diastase Co.,) Maltzyme With Cod Liver Oil (Malt-Diastase Co.,) Maltzyme With Cascara Sagrada, (Malt-Diastase Co.), Malzyme With Iron, Quinia and Strychnia, (Malt-Diastase Co.) Maltzyme With Hypophosphites, (Malt-Diastase Co.,) Maltzyme With Yerba Santa, (Malt-Diastase Co.), Maltzyme Ferrated, (Malt-Diastase Co.)

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THE SIGNIFICANCE OF HYDROCHLORIC ACID IN GASTRIC CARCINOMA.

By JOHN G. SHELDON, M. D., Rosedale, Kansas.

Since the advent of stomach analysis as an aid in the diagnosis of disease, various clinicians have attached more or less importance to the diminution or absence of hydrochloric acid in the gastric contents in the diagnosis of gastric cancer. While, as a rule, the h c l test has not been looked upon as being of decided value in making a diagnosis; the diminution or absence of the stomach h c l has been considered more or less characteristic of cancer of this organ.

During the last 12 months, Moore (12), Alexander (2), Kelly (3) and Roaf (4) have shown that the diminution or absence of hydrochloric acid in the gastric contents is in no way characteristic of cancer of the stomach. These investigators have found that deficiency or absence of h c l is the rule in cancer located in any portion of the body, and their clinical observations show that cancer in the uterus, in the breast, or in any portion of the body is associated with the absence of h c l in the stomach as frequently as is gastric carcinoma. While these observations apparently diminish the diagnostic significance of hydrochloric acid in gastric cancer, those who have studied the subject after carefully considering the facts, that the h c l in the stomach is often markedly diminished or absent in pernicious anaemia and wasting diseases, and as Fiefschuntz (5) has shown, h c l may be normmally diminished in individuals over 50 years of age, still express the opinion that deficient secretion of h c l occurs more often in cancer than in all other conditions and while this gives us no aid in diagnosing cancer of the stomach from cancer in other portions of the body, it must be looked upon as characteristic of cancer in general and of considerable diagnostic significance.

The cause of the diminution or absence of h c l from the gastric contents in carcinoma has been studied since Robert Von den Velden (6) first called attention to it in 1879. The early observers thought it resulted from stenosis of the pylorus. It was believed that when a gastric cancer occluded the pylorus a profuse catarrhal secretion in the stomach followed, and that this neutralized the hydrochloric acid. This theory obtained until 1887, when Honigmann

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(77) Von Noorden (8) disproved its correctness by showing that in stenosis of the pylorus due to non-cancerous conditions h c l was present; and that in many cases of gastric cancer h c l was absent when no pyloric stenosis existed and no gastric dilatation has occurred.

Another theory advanced to explain the absence of h c l in gastric carcinoma, was that there was poured into the stomach, from the ulcerating cancer, a material that neurtalized the acid. This view was apparently strengthened by the work of Beebe (9), Frisbie (10), Loeb (11) and Cowles (12), who showed that cancers contained an excess of potassium. The theory, however, was soon discarded principally for the reason that many times the h c l is absent in cancer of the stomach before ulceration has occurred.

In 1903 Matthiew and Roux (13) stated that the absence of h c l in gastric cancer was due to atrophy of the gastric glands. Vieregge (14) coincided with this view, but most authorities dissent from it—stating that in cancer of the stomach the glandular atrophy theory is not substantiated by histological examinations.

It seems that the explanation for the absence of h c l from the stomach in cancer, is to be found in the chemistry of the blood, and not in local conditions in the stomach. The secretion of h c l in the stomach is, according to Moore (15), Wilson Roaf (16) and others, dependent upon the H or acid ions in the blood. If these are neutralized by OH or basic ions, the secretion of the acid will be interfered with. It appears that carcinoma in any location in the body produces definite blood changes—increasing the basic ions in the plasma and lymph. Micheli (17) and Donati have shown that cancer extracts are haemolytic; and Petry (18) and others, have observed that during cancer haemolysis basic substances are formed. Hober (19) called attention to the fact that these changes dimnished the H ions in the blood; and Emerson (20) first suggested this theory as the explanation of hyopchlorhydria and anhychlorhydaia in cancer. While this theory cannot be accepted as final, clinical observations seem to confirm it. Alexander, and those who have worked with him, report 17 cases of cancer in portions of the body, other than the stomach, showing marked diminution or absence of h c l in the gastric secretion. I have found absence of h c l in two cases of advanced cancer of the rectum. I found it absent in three cases, and markedly diminished in one case, of cancer of the uterus. It was also absent in two cases of cancer of the breast; and diminished in two others.

It is stated by Roaf that the h c l of the stomach does not reappear after operation, but he does not record the number of observations touching on this point. In a case of cancer of the breast, with absence of h c l in the stomach, the acid had reappeared six months after I had removed the breast. This is the only post operative observation I have thus far made regarding the reappearance of h c l after operation.

In the light of these recent clinical and chemical observations, the diagnostic value of h c l in the stomach contents in gastric carcinoma is of minor importance. Its absence or diminution must be considered no more characteristic of cancer of the stomach than of cancer in other portions of the body. It is of value in making a diagnosis only when cancers of the stomach are divided into two classes: First, those following gastric ulceration; Second, those not preceded by ulceration of the stomach. In gastric carcinoma not preceded by ulcer, h c l may be expected to be diminished or absent early in the disease. While in gastric cancer developing on the site of an old ulcer, that has been associated with hyperchlorhydria, the tumor may be well advanced and still h c l be present in the gastric contents.

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DISCUSSION.

Dr Shannon:—I do not know that I shall attempt to discuss these questions. I believe the work is still in the experimental stage. If this was not due to atrophy of the glands, it might be of some value. It would be a very good test for determining whether or not our operation has been successful. The doctor reports one case where the acid was not successful.

Dr. Sheldon:—I have nothing more to say but a word or two in response to Dr. Shannon's observation that this matter is in the experimental stage. My object in presenting this is that the atrophy of glands is no certain diagnosis of gastric carcinoma, that there is a change in the blood in most cases. It might be a test to determine whether or not our operation had been sufficiently able to cure the patient. We ought to take the right view of this matter, and wash the stomach out and determine whether or not hydrochloric acid is present in the stomach. Make this examination before operation and afterward, that we may determine. This thought that I have set before you is largely a theory, but it should be determined what it means.

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THE SUNFLOWER.

By J. N. Winegar, Hamilton, Kans.

From the humble flower of the plains, to the classical emblem among flowers of our state, the one chosen bloom among all the flora, to wear the golden crown of royalty—the queen of flowers, to preside at functions of state and whenever her wand is raised Kansas salutes her. The prototype of aggressive wealth, the synonym of undeveloped possibilities and power; no hot house plant, she lifts her head and asserts her sway in great adversity, teaching a lesson by example; with no well defined or potent alkaloid of healing within herself discovered. Yet her name suggests a force whose potential is maintained by the dynamos of nature, "sunlight." Sunlight is nature's most active antiseptic and germifuge. The greatest in sanitation, the noblest preventative medicine and least heralded of them all. The handmaids of boards of health and the X in their equation. Fluorescence and radiation, those unexplored and unexplained phenomena of light may be the golden key to unlock many secret doors and marshal truths but guessed at now.

To find the how and why of alkaloids and leucocites and phag-

Read before the Kansas Medical Society, Kansas City, Kan., May 10, 1907.

ocites and cells and apsonius in that evasive chemistry of life is difficult and hard to do, but worthy of spartan effort. Nature, always alluring, beckons us on to study deep psychiatry for ways and means to attract and hold the minds and remove or change or pluck out the thoughts that disturb, annoy, harrass, when no lesion is apparent, requires a greater delicacy of skill in touch and technique in such surgery than to amputate a limb or perform a laparotomy.

To scientific research we must look for the Rosetti stone to decipher nature's hieroglyphies and to correctly read her language; to teach and preach the laws of health and prevention of disease continuously, to establish a centralized propaganda that reaches every home within the state and screens from contagion by laws of quarantine, to place competent guardians at the source of food and drink supplies, to see they are not polluted, to cause to be abated any nuisance that may menace health is no mean task accomplished, but worthy emulation.

The end suggests the means to destroy the brood before they breed; to banish the hosts of disease and death, which if allowed free sway would mark their trail with corpses strewn and grinning skeletons would laugh at man's neglect to use the means now well defined. In these affairs it often is that those who profit most yield least reward and lesser still of gratitude. When in the future that Colossus, The Sunflower, is raised goddess and stands guardian at the front door of our state, a tribute to public hygiene and preventative medicine, holding in her right hand the imperial bloom wooing the sun, her left hand reaching ever "upward to the stars" with palm extended to grasp more light, a symbol of education, health, prosperity and happiness, then the medical men of Kansas can put on the ermine they have so nobly won.

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Announcement.

Dr. Sawtell announces the removal of his office from the Rialto Building to rooms 705 706 Bryant Building, Corner Eleventh and Grand Avenue. Home phone, Main 5787.

SCARLET FEVER.

By G. M. Anderson, Beverly.

Gentlemen: The object of this paper is, not to tell what scarlet fever is or the treatment for it, for the text-books tell this better than I can in the time allowed me, but to impress the dangers of a mild epidemic of scarlet fever and to urge the efficiency of a careful quarantine. The idea is almost universal with the public that scarlet fever and scarletina are two different diseases.

They consider scarlet fever a dangerous disease and recognize that it should be quarantined, but a mild epidemic they will class as scarletina or scarlet-rash and will honestly think these cases should not be restricted.

They do not know as you do that these two are one disease and I think it will never be properly controlled until they do know this, because people dislike very much to be quarantined, especially if they consider it unnecessary, as they do if the disease is a mild scarlet fever. So they avoid quarantine by not employing a physician, and their neighbor's children get the disease and his neighbor's children and so it spreads. Then there is a severe case and a death, due to the first case not being isolated, and farther back, due to people thinking scarletina is not scarlet fever.

I think two reasons will explain the prevalence of this idea.

First: We have the two names for one disease and although we use them interchangeably the laity does not.

Second: Most epidemics are very mild but we occasionally hear or know of one much more severe, so that it looks like two different diseases, and then the fact of having two names completes the confusion and people are positive that the diseases are separate and distinct. I may not have made a plain case of this, but so plausible is it as it transpires that many physicians who have seen only mild epidemics have made the error of assuming that advanced therapeutics and a better treatment of the disease has absolutely modified scarlet fever, and that it is not the same as is described by authors of one hundred years ago and this mistake has been made by some of our ablest men.

About thirty years ago there was a practitioner of large experience assisting in the authorship of a text-book on practice, and in writing of scarlet fever he said something near as I have given

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above, that a better knowledge of the nature and treatment of scarlet fever has made it possible for us to reduce the mortality very much, and it is a disease we no longer dread as did the physicians of a generation ago. While this article was in the hands of the publishers a severe epidemic of scarlet fever broke out in the city where this man was practicing, and he was called on to treat many cases and he lost a number of those he treated. Before the book was printed he rewrote the section on scarlet fever and made no claims that it was greatly modified or that his treatment was better than used years before. In many mild epidemics of scarlet fever isolated cases occur which are very severe, and in which death occurs almost before treatment can be instituted.

I shall not attempt an explanation of this great difference in the severity of different cases, but we all know there is this diversity also many cases in these milder epidemics are left deaf or with kidney lesions or suppurating glands or some localized trouble.

I wish to give the history of four fatal cases which have come under my own observation in the past year, illustrating the dangers of this disease.

Fisrt: A boy five years old had scarlet fever in January, 1906; not severe. I was not called to see him at that time. About three months later he was out with his father one day and got wet and soon had a severe nephritis, from which he died last June.

Second: A boy two years old was taken sick in March last. A physician was called and pronounced it scarlet fever, which was prevalent in the town in a mild form, but he did not have the family quarantined. The little fellow died in less than a week, and they were not quarantined until two days before his death, when I was called, although other members of the family had the disease for fully two weeks previous.

Third: A case I may not give correctly, as I was not the attending physician. A boy four years old took the disease from a younger child which was said to have scarlet rash, and he died in five days. April last.

Fourth: The last of November past my wife and four year old girl went to Wichita for Thanksgiving. There was a child on the train a little sick. Three days later our little girl took violently sick with scarlet fever and died in less than four days.

The only possibility of contagion that we could trace being some one they met, probably the child mentioned.

These four cases given show plainly two grave dangers of these

mild cases; one the danger to the individual himself of some complication following, of which I have given an example of only one, —i. e., Nephritis; and the other the danger of another contracting the disease and having it in violent form. If my paper were to close here I think my view of scarlet fever could be called a very pessimistic one, for I do not think there has been the advance made in the knowledge of the cause of scarlet fever that there has with many other of the diseases we treat, and I doubt much if our treatment is greatly more effective than the treatment formerly used, but one thing we have learned, and that is that quarantine is more effective here than anywhere else.

With very moderate precaution there will be no spread of this disease except where people are crowded.

To show how easily controlled by quarantine I will give two cases from my own practice within but little more than a year.

March, 1906, a little girl in Beverly had scarlet fever. No other children in the family. Quarantined. There were no other cases in town at this time, and none following. In December, 1906, I had scarlet fever and was under quarantine four weeks. There were no other cases in town at this time and none following.

If I could describe some new operation that would save a few lives each year you would think it wonderful, yet we, working together, can save some lives every year in Kansas by the plan I have tried to outline. That is by teaching people that there is no scarlet rash—that these cases are scarlet fever and are dangerous, and by impressing the fact upon them that it is criminal to carelessly spread this or any other disease, and last, by promptly quarantining the first and every case we see.

If we do these three things we will certainly save some lives that would be sacrificed under present conditions.

DISCUSSION.

Dr. Brookhart:—I am heartily in favor of the doctor's paper and what he has to say about quarantine. In the last few months I have had several cases of scarlet fever. I have had a great deal of trouble to keep patients quarantined: and, it is largely due to the fact that there are a great many doctors who say "scarlet rash" is not scarlet fever. I was called in for suppurating glands of the neck. I opened five abscesses in the neck of that little child and her people had thought they only had "sacrlet rash" in the family. It seems to me that the use of the term should be discontinued, for it leads to great harm.

Dr. Robinson:—There is a great deal of trouble as the result of the mild cases of scarlet fever If the children are not much sick, the family

does not employ a physician. They get well in a few days. Nothing is done toward quarantining, some other child is exposed to the disease and dies from its effects. I was called to a place to see a child that was sick from some intestinal trouble. I observed that the epidermis had peeled from the hands, the face and the body. I have reason to believe that the whole family of eight or nine children had had scarlet fever. During my rounds in the next few days I found several families who had had scarlet fever without employing a physician. In such cases, we are practically powerless to enforce quarantine. We find the same trouble with smallpox. I had an experience in my town. I had a family quarantined who had smallpox. I had my family vaccinated; they broke out as a result of the vaccination; and, this family whom I had had quarantined wanted to have my family quarantined on account of it.

Dr. Browne, Leavenworth:—I want to tell of two cases that I had. One was that of a little girl who had a very light case, practically not sick at all—would not go to bed. In taking care of her, we told the mother what to do in case another child got it. In two or three days after the little girl broke out, we went there and saw the second child, and inside of six weeks, it was dead. Probably from acute nephritis, as there was no urine passed after the child showed that she was sick. This was during a very mild epidemic of scarlet fever in Leavenworth. Many had it, but were not quarantined. I was severely criticized for quarantining people who were not very sick. I insisted on quarantining everybody who had a suspicious looking rash at that time. I have been told in another case that a physician told the family that the child had "strawberry rash." If you can tell me what "strawberry rash" is, I wish you would. The child was not very sick, but they thought it would be better off out on a farm; so they sent it out to visit some cousins. A little five year old child whom I knew well (one of the cousins) was dead inside of two weeks. She had suppurating glands of the neck and died as a result. If there is one thing I want to say it is, let us be strict in our quarantine. It is better to quarantine one dozen unnecessary families than to have one death as a result of not enough quarantine.

Dr. Porter:—I do not think that quarantine is sufficient. After quarantine, disinfection is necessary. I remember an epidemic that occurred in my practice. I traced it to the opening of a book that had been played with by children who had had scarlet fever two years before. The book was laid away carefully; and, after two years' time was brought out to show pictures to some children. In three or four days, they had scarlet fever and an epidemic was the result. Had they been thoroughly fumigated, several lives would have been saved. Another thing is: A great many people think that as soon as the rash has disappeared, the patient should be turned loose This is not a fact. Every case should be quarantined at least four weeks; regardless of appearances. If there is anything at the end of that time that seems to be wrong—abscesses, discharge, etc.,—they should still be confined in quarantine. It is one of the easiest diseases to quarantine that we have to deal with The very mildest form of the disease in one may produce the severest form in another.

Dr. Best:—A few years ago there was a case of scarlet fever happened in a very prominent family in our town. The child's grandparents were over in Germany. A child in a friend's family died over there. The grandparents wrote of it to this family; and, this child suffered exactly like it. It lived only about four days. The fever was 104. There was no history of that child's ever having been exposed. Would it have been possible for those germs to have been brought across the ocean in that letter? It caused considerable discussion at the time it happened. I should like to know. There is one other little point. Children, of course, should be kept very carefully in the house after having the mildest case of scarlet fever. The mildest case may die later of the disease. The mild cases often develop the most fatal sequellae. That is why this disease has caused so much discussion. It is not many years since they almost denied that there was such a disease—it affected people in such varied ways that it was difficult to learn of it.

Dr. Blasdel:—I was just wondering before the brother got up on this matter. I had a case similar to that he related, although the infection did not come so far. I was called to see a girl four or five years old with unmistakable scarlet fever. She ran the usual course and got well. No one else became infected. The family absolutely knew of no place where they had any scarlet fever in the neighborhood. After I had discharged the case, there came a letter from a brother who told of their having an epidemic of scarlet fever in their vicinity. Just before the little girl got sick they had received a letter from this brother. Undoubtedly the letter had carried the germs to the little girl.

Dr. Dillon:—I have no criticism to offer to the paper the doctor gave. There are a few things which might be added. In the first place, why do the people think that there is a scarlet rash, a scarletina, a rose rash, all different from scarlet fever? Simply because the physicians have told them so. All the doctors who come to the medical societies know this. Those who do not come, do not know; and, they are teaching the laity this today. One thing more; regarding the vitality of the germ. I suppose that most of us can go back into our experience and tell of cases of its having been transmitted in these curious ways. It would take the whole afternoon and then the story would not be half told. If the germ can be carried for one way in a letter, it may be carried clear across the ocean in a letter. I know of a case where the family laid away the clothes of a little child who died of scarletina; and, a few years after, these clothes were given to another child and this child started an epidemic. However, I do want to state that possibly the doctor who wrote this excellent paper has been negligent himself. He had the disease himself only a few months ago, if I understand him correctly Evidently, the disease had been lingering in the house from the death of the child until the father took sick. You must kill the germ; or it may live twenty-four months and start an epidemic.

Dr. Barnett:—I simply want to refer to a case that happened in my practice a few years ago. The case was one that was said to be a mixed infection of scarlet fever and diphtheria. The child had a box of trinkets.

The little one died. After the death of the child, that box of trinkets was sent to a brother who had four children. In the required time—almost to the day— those children took down with a mixed infection of scarlet fever and diptheria. That is authentic. The case was thoroughly investigated. The physician should in all cases of rash give the public the benefit of the doubt of the diagnosis. It is better to do injustice to one family and place them under an unnecessary quarantine than to do injustice to a whole neighborhood by not quarantining one family that should be quarantined. You may earn enmity; but, what does that amount to if you are doing your duty? About a year ago, I was called to see a girl about 13 years old who was in convulsions. I could get no case history. After I succeeded in bringing her over that crisis, I then tried to find out the possible cause. She had had German measles the Christmas previous, the doctor said it was German measles. I got a specimen of the girl's urine, made an examination, and found that I had a case of nephritis caused by a case of sacriet fever diagnosed as German measles. That girl, with all the careful treatment possible, still shows traces of that trouble. I believe that in many cases an epidemic of scarlet fever is caused by a careless diagnosis. Many girls working here in the city in department stores, have scarlet fever so lightly that they never know they have it. They wrap packages and send them broadcast over the city. What is the result? Epidemic scarlet fever.

Dr. Goddard:—My experience is that history repeats itself pretty often. Forty or fifty years ago at the first medical society I ever attended, I must have heard this same discussion. It is the same old story.

Dr. Anderson:—The point of disinfection was well taken. Quarantine is of no use unless we disinfect afterward. I read a notice in the Topeka paper that stated that a man had been quarantined for scarlet fever for two weeks. He did not want to disinfect until his fancy chickens were hatched. Quarantine is very often too short. While it is true it is sometimes taught by physicians that these various named diseases are different, I think it is more often taught by not teaching anything in regard to it. In regard to my own case, where the doctor spoke of negligence. That was merely a misunderstanding. The baby died the third of April; and, on the seventh, I took sick.

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HOW NOT TO DO IT.

By EDWIN TAYLOR SHELLY, M. D. Atchison, Kansas.

While no great crying need may exist for additional evidence confirmatory of the truism that "the next best thing to knowing what to do is to know what not to do," another proof of the truth of this adage nevertheless will be submitted. Spurred on by the urging of such men as Denslow Lewis, Prince A. Morrow, Chas. E. Woodruff and others, that medical men should take it upon themselves to disseminate throughout their respective communities much needed information concerning the venereal peril, I sent the following communication to two daily papers in succession. The reception which it received at the hands of the Atchison Daily Globe is portrayed in the following clipping from that paper:

"One of the physicians in Atchison has sent a well-written and important letter to this office which we cannot publish, as it relates to the sexual question. There is no other social question of equal importance, but newspapers must remain quiet with reference to it. If we should publish this letter, there would be a commotion; many people would be horrified. But the letter is true, very important, and has the endorsement, we are informed, of six Atchison physicians. Young people are denied much knowledge that is of the greatest importance. It isn't taught in the schools; it isnt' referred to in the newspapers or magazines. We believe the letter should be published, but are afraid of those who are of a different opinion. All of us, by the way, are influenced by those who entertain notions we do not accept."

The Kansas City Star returned the article with only a stereotyped declination to publish it. The following communication is therefore an example of how NOT to attempt a matter of this kind:

DANGERS OF UNCHASTITY.

Perhaps the most difficult matter to treat acceptably in a lay publication is that of unchastity, particularly from any other than a purely moral aspect. Indeed, nothing but the superlative importance of this subject to the rising generation could induce any one with the least dread of the frowns of Mrs. Grundy to venture upon so unconventional and thankless a task.

While nearly every one who has reached the years even of adolescense realizes quite thoroughly the advisability, from a moral standpoint, of leading a chaste life, there are nevertheless, still too many persons who look upon chastity as an ideal condition which should be maintained inviolate by one sex, but which may

be demanded with less rigidity of the other sex. And yet there is no reason, physical or ethical, why the two sexes should not be expected to occupy exactly the same plane in this regard. Nature, at all events, is impartial in the matter, and is as ready to punish infractions of chastity in the one sex as in the other, although, it must be confessed, with unequal severity, at times. Of this punishment this article is especially to treat.

There are two prominent diseases which may result from illicit relations. One of them is chiefly, although not entirely a local inflammatory disorder, while the other is mainly a constitutional infection requiring the continued treatment of years for its eradication. Even then it often reasserts itself in the individual or in his progeny in the form of horrible blemishes, deformities or serious brain or nervous disorders. As considerable knowledge of the latter disease exists among all classes of people, its further consideration for the purpose of this paper may be omitted.

The former and more nearly local disorder needs, however, to be considered more at length, because of the fact that it is usually referred to as a more or less insignificant affection and easily curable. This popular notion is reflected in the remark often heard: "It isn't as bad as a severe cold;" and an apparent cure effected occasionally in the course of a few weeks, lends plausibility to this unfortunate delusion. The truth of the matter is, however, that the best experts in the treatment of this disease maintain that really to cure it is one of the most difficult tasks in the domain of medicine and surgery. While a cure often takes place after very persistent treatment, too frequently only the symptoms of the disease abate, while its germs still remain, although they may be so nearly dormant for months or even for years, that their presence is no longer suspected. Should the connubial relation now be assumed, the possible results to the innocent, unsuspecting bride may be read in the following "Story of Rose and Edward," which appeared originally in The Critic and Guide, a medical journal, and which has since been going the rounds of other medical publications.

"Miss Rose was a little over twenty-two. She was a bright, cheerful, happy girl—happy not only because on that day she was graduated from Barnard with high honors, but Edward—Dear Ed—whom she loved and looked up to for so many years, had proposed last night; and the passion, romance and aroma of the proposal still lingered with her. . . . And Ed was a husband to be proud of. Though but twenty-eight years old he had already

achieved eminence in the legal profession, and his practice was larger than he could attend to. He was kind-hearted, a gentleman in the noblest sense of the word, and an all-round athlete—a man to protect a woman from every possible care, and make her happy as long as she lived. So thought Rose, and she was right.

"They were married in October. They expected to be away three months on their honeymoon, but they returned after about three weeks. Rose was not feeling well, and traveling and staying in hotels did not agree with her. She looked rather tired and fagged out, but that was natural. It was not natural, however, that after a week's rest she did not show any improvement. On the contrary, she began to look somewhat haggard. . . . Things continued in this way, getting a little better and a little worse, until the beginning of January. On the fifth of January, she was taken violently and dangerously ill with severe abdominal pain, a very hard and rapid pulse and threatening collapse. Her physician called in a consulting surgeon, and it was decided that in order to save the patient's life an immediate operation was necessary, and, though it was midnight, the patient was quickly removed to a hospital and operated upon. About three and a half pints of a blood-stained and somewhat purulent serum were removed from her abdomen, and a microscopal examination of this serum demonstrated the presence of tell-tale microbes . . . . The operation was a "success," but—the patient was unsexed.

"A confidential talk with Mr. Edward was held. He searched his memory for a while;—yes, some two years ago he had had a little trouble, . . .but he was all right again in three or four weeks.

"Rose recovered, but you would hardly know her. She aged ten years in ten weeks. She is making no plans, she has no hopes, she is dreaming no dreams—not for the present, at any rate. Never again will she be the happy Rose that she was before she became Mrs. Edward. Never will her home be gladdened by the noise, romp and laughter of little children.

"Who is to blame? Nobody. Rose certainly is not, nor is Ed, for he certainly would have had his right hand cut off—and his left one too—rather than cause the woman he loved above all else in the world any pain or suffering. But he 'didn't know', and we cannot be blamed for the things we do not know, and that we never were told that we ought to know. Should we blame those who insist that all knowledge of sexual matters be kept away from the people? Perhaps; but even they are more to be pitied than blamed;

for they are generally sincere in their beliefs and we cannot blame them for their ignorance."

The awful surgical tragedy just portrayed is, sad to say, duplicated with more or less accuracy somewhere in this country many times every hour of every day of every week in the year.

But retarded and unlooked for troubles due to this disease are not confined to one sex. Years and years after the original infection has taken place—often after middle age—the results of its insidious, destructive processes become manifest in local disturbances accompanied by the keenest annoyances and distress, and resulting frequently in a fatal termination. Such, then, are a few, and only a few, of the physical consequences of unchastity. Surely if it were at all appreciated what unspeakably dreadful risks are taken by indulgence in this sin, even the instinct of self-preservation would guard men and women from falling into its maelstrom. But ignorance on this subject has made them indifferent to its dangers, and they therefore allow themselves to succumb too easily to the imperious promptings of a riotous instinct which should be controlled instead of obeyed.

The fact that this instinct exists and is "natural" is often offered as a physiological excuse for its indulgence. The truth, however, is that the universal verdict of physiologists and medical men who have made this subject a study is absolutely opposed to this notion. On the contrary, they all agree that this excuse is untenable and that the existence of unchastity has no better physiological reason for its being than it has moral warrant; and the enormity of unchastity from a moral standpoint is universally admitted.

If, then, unchaste living is thoroughly wrong morally; if it is utterly indefensible physiologically; and if, in addition, it offers the greatest physical dangers to which any individual or the race even can be exposed, why should any sane man or woman need to be urged to avoid such a fatuous, fatal folly?

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MERCURIAL STOMATITIS.

By D. D. HAGGARD, M. D., Phillipsburg, Kansas.

Stomatitis, or inflammation of the mouth, presents a great variety of forms.

The following are among those most commonly observed:

1. CATARRHAL—Caused by nervous irritation incident to teething, or some Gastro-Intestinal trouble. There is a feverish condition of the mouth with oedema of the tongue and increase of saliva.

2. FOLLICULAR—In this form ressicles appear on the tongue, lips or inner side of the cheeks, these soon rupture, leaving in those places a small gray ulcer, which makes the ingestion of food a very disagreeable procedure.

3. PARASITIC—This variety, in popular language, called Thrush, is due to the presence of a fungus, Saccharomyces Albicans. It appears on the tongue as small grayish spots, which have a tendency to run together and form paths. Sometimes the disease becomes very extensive, involving the entire throat.

4. ARUMATIC—This form as its name would indicate, is the result of wounds or injuries produced by the caustic action of alkalies, acids or other destructive agents.

5. MERCURIAL—This form is caused by the inhalation of mercury vapors, or the absorption or ingestion of mercury in some form.

Some individuals seem to be especially sensitive to the influence of mercury and a very small dose will produce marked physiological action. It is of this latter form that I wish to speak.

DIAGNOSIS.

The diagnosis is usually very simple as the symptoms are characteristic.

The patient usually complains of a metallic taste in the mouth. The teeth convey the impression of soreness, especially when they are brought together as in mastication. The flow of saliva is increased and occasionally the quantity secreted is enormous. The breath becomes very offensive and naturally anarexia is complete. In most cases nervousness is a pronounced symptom.

PROGNOSIS.

The prognosis is usually good, for with appropriate treatment

recovery usually occurs within two or three weeks.

REPORT OF CASE.

On Sept. 5th, I was consulted by a young lady for a slight indisposition. The patient was about five feet tall, and weighed about 130 pounds. She was remarkably developed every way for her age, as she was between fourteen and fifteen years old.

The kidneys were normal. The menses were normal both in quantity and occurrence. There was, however, a history, of occasional constipation.

As preliminary treatment I prescribed ten calomel tablets, in all one grain.

The composition of each tablet follows.

Calomel 1-10; bismuth subnitrate 1-10; sugar of milk q-s-to make 1.grain.

These tablets, ten in number, were to be taken one every half-hour, the last to be followed by 2 heaping teaspoonfuls of effervesing magnesium sulphate in a glass of water.

I was notified, an hour after the salts had been taken, that no bowel action had occurred. I ordered an immediate repetition of the dose of salts. The second dose produced the desired movement.

I heard nothing more from the case until the 8th instant, three days later, when I was requested to call and see the patient on account of her sore mouth. The moment I entered her bed chamber I saw I had a case of Mercurial Stomatitis to deal with. The lips were enormously swollen and were nearly covered with dirty greyish crusts similar to Herpes Facialis or Impetigo. The mouth was held partly open and the swollen gums and enlarged tongue made the diagnosis easy. The teeth were very tender and shutting the mouth increased the discomfort. The breath was offensive, and there was a disagreeable flow of thick saliva, which was very annoying, although not extremely excessive. The gums were soft and gave the impression of recession from the teeth. The appetite was entirely gone, and the patient was extremely nervous, although the temperature and pulse were practically normal.

TREATMENT.

Local applications of ice water were made until the swelling was reduced. Tablets of Potassium Chlorate were administered, being placed on the tongue, with instructions to allow them to dissolve, the patient to swallow the medicated saliva. The bowels

were kept flushed with magnesium salts. Glycerine and cream applied to the crusts softened them and facilitated their removal. In about a week's time the trouble was over, crusts all gone and the patient went about her usual duties.

REMARKS.

I think the reason Ptyolism occurred in this case was that the calomel was not given in sufficient quantity to overcome the constipation and produce a speedy elimination of the mercury. Profiting by this experience I shall ALWAYS PRECEDE the administration of calomel with a thorough flushing of the bowels.

—o—

So great has been the demand that W. B. Saunders Company, the medical publishers of Philadelphia and London, have found it necessary to issue another revised edition of their illustrated catalog of medical and surgical books. In looking through the copy we have received, we find that since the issuance of the last edition six months ago, the publishers have placed on the market some twenty-five new books and new editions—truly an indication of publishing activity. The colored insert plate from Keen's new Surgery, which enhanced the value of the former edition, has been replaced by a new one from the second volume of the same work, and this alone gives the catalogue a real value. A copy will be sent to any physician upon request.

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The Council on Pharmacy and Chemistry report that the following preparations come up to the standard test. The following articles were added to the list: Benzo-Formol Comp., (H. K. Mulford Co.), Blandine Comp. (H. K. Mulford Co'.) Cremo-Bismuth, (H. K. Mulford Co.,) Methyl-Santal, (H. K. Mulford Co), Protan, (H. K. Mulford Co), Coryfin, (Farbenfabriken of Elberfeld Co), Monotal (Farbenfabriken of Elberfeld Co.), Novaspirin, (Farbenfabriken of Elberfeld Co.)

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G. Frank Lydston (Med. Rec., September 14, 1907), gives an account of three cases in which typhoid fever complicated surgical conditions to illustrate the point that we must always be on the lookout for this disease in the course of surgical cases.

ABSTRACTS.

Life Insurance Examination Fees.

Your committee appointed to prepare resolutions on the question of a suitable fee for insurance examinations of old line companies," respectfully submits the following report:

I. The fee to be asked for an examination for a life insurance company should be determined by the same rules that decide the value of our services to private patients.

It is impossible, consqeuently, to state any sum as a binding or authorative fee, since physicians place different prices on the value of their services. It might be remarked in passing, that those physicians who habitually value their service at a lower price than is ordinarily charged by their neighbors, are receiving all that their services are worth with a possibility of being overpaid. All that can be offered in a report of this kind is an estimate of a fair, minimum fee for the self-respecting physician of average standing Such a man will adhere to a fair fee, regardless of the "cut rate" fees by others even at the risk of personal financial loss. His dignity as a gentleman, the honor of his profession, the debt he owes to it, and the regard of right living (more valuable and satisfying than any money gain) all demand this. Your committee will not urge the adoption of its conclusions, as a combination to maintain "rates", but their acceptance by each one individually, as far as it appears right to each individual, because it is right, oblivious of the conclusion of any one else.

II. In determining the value of the services included in a life insurance examination, we must keep in mind:—

1. That an examination which partakes of some of the features of a consultation, commands a relatively higher price than the same examination for the exclusive use of the examiner.

2. That an examination plus a written report with an opinion, is worth more than an identical examination without a written report, with a verbal opinion to the patient alone.

3. That a physician is justified in charging a larger fee for an examination where he is only to give an opinion than where the examination is to be followed by a series of fees in the course of treatment.

III. Keeping these propositions in mind, let us try to make out a bill of items:—

Should a patient call at the office of any of our number and re-

quire, for the proper understanding of his condition, an examination such as is usually included in the routine life examination, few, if any, of us would ask less than one dollar for the service rendered; most of us would ask more. Then, if an urinalysis were required, an additional dollar would be demanded. Should the patient at the start have told you that he was asking for this examination only to learn his physical condition and that he did not purpose to put himself under your professional care, we doubt if many, unless under some stress, would not raise the fee they had proposed to ask by fifty cents or even a dollar more. If, in addition, you were asked to write a full report of your findings, detailing with some minuteness the conditions of the various organs, which report is to be used by Dr. X. to assist him in giving an opinion for which he is to be paid, should you double the amount thought of for a fee, it would not be excessive. Indeed, were your patient ordinarily well to do, most of you, when asked the amount of your fee for performing such service, would quietly say "ten dollars" and the fee be cheerfully paid and thought to be a reasonable one.

IV. If through custom or the result of conference a minimum fee prevails in any region, the only valid reasons for diminishing the amount are that the particular examination in hand (1) requires less skill; (2) takes less time; (3) involves smaller responsibility, or (4) the financial condition of the patient demands a concession.

If none of these elements be present, ordinary decency demands that we manitain the fee. Not that we are bound by any pledge, but, if a man has any conceit of himself, he ought to value his services to be worth as much as those of his neighbor; and, if he has any respect for his profession, he will uphold her dignity and not engage in a custom that is off color even in the commercial world. He will not "cut prices."

V. Certain life insurance companies accepted the idea that five dollars was a proper fee for an examination of an applicant for insurance in their companies. Now they have notified their medical examiners of a reduction in the fee to be paid for a number, probably the majority, of the examinations. We have seen above that five dollars is a very moderate fee for the service rendered. Do the companies reducing their fees claim any of the reasons already quoted as a reason why this reduction should be acctepted by the physicians? The new examinations will require as much time, exact as much skill, and demand as much responsibility as they

formerly did. Their only reason can be the financial one. Is this a valid reason?

VI. Because of abuses in the conduct of life insurance companies, there has been new legislation and the companies are limited in the amount of their expenditures. Because of this legal restriction, the companies ask their medical advisers to reduce their fees. In order that there be no misrepresentation on the part of your committee in the presentation of this claim, we quote from a letter of a president of one of the companies reducing their medical examination fees. It was sent to one of the examiners of the company in defense of the action of the company:

"It appears, from articles which I have seen in certain medical journals and from the action of some medical societies, that the physicians of the country are not aware of the causes which led to the change in the medical fees allowed by the ——— and by other companies. This change has been necessitated by the new legislation, and it seems to me advisable to explain to you the requirements of this law in some detail. The section to which I refer reads as follows:—

"Section 97. Limitation of Expenses. No domestic life insurance corporation shall in any calendar year after the year nineteen hundred and six spend or become liable for or permit any persons, firm or corporation to expend on its behalf or under any agreement with it (1) for commissions on first years premium, (2) for compensation, not paid by commission, for services in obtaining new insurance exclusive of salaries paid in good faith for agency supervision either at the home office or at branch office, (3) for medical examinations of proposed risks, and (4) for advances to agents, an amount exceeding in the aggregate the total loadings upon the premiums for the first year of insurance received in said calendar year (calculated on the basis of the American experience table of mortality with interest at the rate of three and one half per centum per annum) and the present values of the assumed mortality gains for the first five years of insurance on the policies on which the first premium, or installment thereof, has been received during said calendar year, as ascertained by the select and ultimate method of valuation as provided in Section eighty-four of this chapter."

In brief, this Section means that the four items referred to are directly chargeable against new business, and that the companies are not allowed to spend in total for these four items an amount in excess of the actual margin of loadings on the new premiums paid plus the mortality gain. This law will, in any event, necessitate a very great reduction in commissions paid to agents, and I think it will be extremely difficult to retain in our employ many of the men who have been working for us in the past. The agent is the one who will feel most particularly this reduction."

We interrupt the quotation to call your attention to the reasoning employed. Certain abuses crept into the management of the life insurance companies, among others, excessive commissions to agents. The legislature, in its efforts to prevent the recurrence or continuance of these abuses, limits the amount of expenditures. This will reduce the amount of the commissions paid to agents to such a degree that the company fears it will not be able to retain the agents heretofore overpaid. That it may be able to make as small a reduction as possible, it proposes to reduce the fee of the medical examiner, which was not thought to have been too large, thus taxing him to assist in the soliciting of business. It is possible to explain this method of procedure only on the supposition that the doctors, or some of them, are always willing to accept any old thing that may be offered to them. Resuming our quotation:—

"In the case of policies of any material size, say $3000 or over, there will be margin enough to provide for the old medical fee of $5.00; but on smaller policies, inasmuch as the medical fee has not under the old schedule borne any relation to the size of the premium collected, there is a very small margin left for the agent after paying the old fee and the cost of inspection.

The following table will explain my meaning:

ORDINARY LIFE

Age	Prem	Loading and Mortality Gain	Balance for Agent	Per Cent
25	20.84	15.35	9.35	45
30	23.72	16.59	10.59	45
40	32.43	20.62	14.62	45
		TWENTY-YEAR ENDOWMENT		
25	49.45	19.40	13.40	27
30	50.28	20.27	14.27	28
40	53.46	23.49	17.49	33

This balance for agent in column four is after paying $5.00 medical fee and the cost of inspection.

You will see from this table (which is only approximate and in which table the possible commission which we will be able to pay the agent is probably in excess of what we can actually pay) that the percentage which a $5.00 medical fee bears to the figures in the column headed "Loading and Mortality Gain" is excessive, and that the change which we have made was really forced upon us by the law; e. g., a medical fee of $5.00 on an ordinary life policy for $1000 would absorb one-third of the entire figure which the company under this law is allowed to expend in securing this business. If the same ordinary life policy were for $3000, the loading and

mortality gain would be $45.00 and the medical fee still the same; viz, $5.00, or one-ninth of the amount allowed to the company for expenditure.

I think if you will examine the underlying principle of this law, and will study the above table, you will see the necessity and the justice of the position we have taken."

We do not wish to discuss the arguments of this letter at length, but since the company of which the writer of the above letter is the president offers a three dollar fee for an examination when the policy is for $1000, it is fair to infer that it does not consider that the physician is receiving an excessive fee should he be given twenty per cent of the sum permitted by the law to be expended. Would it not be simple justice, just ordinary business honesty, without any sentiment mingled with it) if the fee is to be added to the amount of the policy, that when the amount of the policy amounts to $3000, the fee should be in the same ratio, or $9.00, not the $5.00 which the company offers. And, although the figures are kept from us in this letter, if the increase at all correpsonds as the amount of the policy increases, what can we say of the princely munificence or reckless extravagance of offering a fee of $7.50 for the examination when the policy is for $15,000?

Neither will it be wise for your committee to enter into a discussion upon the proper amounts to be paid to agents for securing business, since we are not acquainted with all the facts. We will only call your attention to the following: (1) The legislative committee that framed the act was aware of the amount paid for the examinations and thought the sum left after such payment had been made to be ample for the compensation of the agents. (2) The letter clearly shows that the insurance companies dread the loss of agents by the reduction of the fees, although they had been receiving excessive commissions; while they expect the physician to accept mildly anything that may be offered to him. In this they but reason the almost uniform action of the profession for a period indefinitely long in the past, which has resulted in the uniform belittling of the value of the services of the physician when rendered to the public or to corporations.

But, after all, is there any reason in all this for accepting a three dollar fee? Does not the physician give as much for the $1000 application as for one for $3000 or $10,000? If the agent be required to take an insufficient fee for securing a thousand dollar application, that will be an incentive to him to secure the issuing of

policies for larger amounts. Of the reasons given, justifying the reduction of a fee, we have seen that the only one that applies to the question under discussion is the poverty of the patient,—in this instance the insurance company. Do you think these corporations fit objects on whom to bestow your charity?

Wherefor your committee sees no valid reasons for accepting the reduction of the fee.

VII. The discussion, thus far, has related to those companies which have been paying five dollars and now wish to reduce it. There are companies that never paid over three dollars and have found no difficulty in securing examiners. Your committee can see no reason why these companies should not be asked to advance their fees. If our contention is true, that five dollars is less than we would be apt to ask an individual for the same service, we ought to demand this as a minimum fee for any full life insurance examination, and let the company find whom they can if they are not willing to pay it.

We would note that the acceptance of such a fee works harm to the profession at large. Your committee quotes from another letter, this time from a medical director of one of the companies that were forced to show their extravagant expenditures in certain directions, under the skillful questioning of Governor Hughes. It might be remarked, in passing, that the examination did not reveal the amount of the salaries of the medical directors, although the question was asked definitely, nor does a careful search of the records at the Insurance Department at Albany furnish the information.

Your favor of the 18th instant is at hand. I shall have to enter a protest against one statement in it. Judging by the standard which physicians themselves have set, $3.00 is an adequate fee for the service we require. Our former payment, therefore, of $500 was an extravagance. Out of 298 insurance organizations in the United States only nineteen have a flat fee of $5.00, of the others eleven have a graduated schedule similar to ours, and the remaining 268 have a flat fee of three dollars or less.

This, remember, is from a medical man, one of those whom rumor saith receives anywhere from $25.00 to $50.00 for each and every hour spent in the office of the company, whose salaries are so large that the officials of the company did not know their amount when the affairs of the company were under official investigation. It is such a one that says the payment of "$5.000 was an extravagance." But, after all, the sting in his letter lies in the

fact that physicians are found who will take whatever they get regardless of the true value of the service, and of its effects upon the profession at large. We can not but think that much of this is done through thoughtlessness.

VIII. This report does not touch the various forms of industrial insurance. There are other factors entering into that department of insurance which require a separate consideration, and the introduction of it here would fog the main issue.

We believe that we have stated correctly the principles involved in determining the proper fee to ask for a life insurance examination. We, therefore, recommend the adoption of the following:—

Resolved, That the Medical Society of Northampton County affirms, as an abstract proposition, that five dollars is as small a fee as should be charged for a full, regular examination for a life insurance company.

Resolved, That the physicians in this county be asked to live up to this abstract proposition in their practice, and to decline to make an examination for less. Not because it is a concert of action on the part of the physicians, but because it is the right thing to do.

Resolved, That a copy of this report be sent to every physician in the county, with the request that free and candid comments be made upon it, and that the committee be continued to receive and report on these replies.

Resolved, That the necessary expenses for printing, postage and clerical assistance in sending out this report be paid by the society after the bill has been approved upon its presentation in the open meeting of the society.

CHARLES M'INTIRE.
W. P. WALKER.

NEWS AND NOTES.

The New Municipal Kansas City Hospital.

It will be remembered that Thomas Swope gave the ground for this new hospital, which is located on the high ground a few blocks from the site of the new union depot. The Kansas City Times has this to say about the new building:

"The new general hospital will not be finished until next spring. Because it wants to learn how much money is available, the board of public works decided yesterday to postpone the awarding of contracts for interior furnishings.

The board believes the hospital will be ready for occupancy April 1. It will cost about $406,000. The bond issue for the hospital was $225,000. The $406,000 includes the purchase of the Norton site, a small piece of ground on the north side of the hospital grounds. The condemnation proceedings for this piece of ground is pending in the Missouri supreme court on an appeal to test the right of the board of public works to condemn land for public purposes. The board has deposited $8,000 to pay for this land when the appeal is decided. It is estimated that the cost of the interior finishings will be about $6,800. The contracts for glass, cement floors, painting and plumbing connections will probably be awarded next Tuesday.

"The bond issue of $225,000 voted for the erection of the hospital was spent by the board in erecting the building," P. S. Brown, Jr., a member of the board said yesterday. "Details of the exterior and interior finishing have been provided for by special appropriations from the city council. Aside from the new Philadelphia general hospital now building, the Kansas City hospital will be the best structure of its kind in the West. Its ward capacity is to be three times that of the present building at Twenty-second and Cherry streets. It has been estimated by the architects that there will be a capacity for over six hundred patients in the new hospital."

The board has not decided what it will do with the old hospital grounds and buildings when they are abandoned. Dr. St. Elmo Sanders, city physician, has suggested that the grounds be converted into a hospital park."

The Phoenix Mutual Life Insurance Co. is another one of the Old Line Insurance companies who has raised the examination fee to five dollars.

Here is an Opportunity for Someone.

The following advertisement is clipped from the "want" column of the Kansas City Times. Are these "case-taking doctors" operating in your town? If they have not arrived yet, an ounce of prevention might be worth a pound of cure.

CASE-TAKING DOCTORS TO TRAVEL, medical institute 1110 N. 6th, Kansas City, Kan.

At least it would be well for every reader to note the name and address of this institution—for future reference.

BOOK REVIEW.

Dyspnoea and Cyanosis.—The first of a series of monographs by Prof. Dr. Edmund von Neusser of Vienna. Translated by Dr. Andrew McFarlane of Albany, N. Y. Octavo, cloth, pp 204, New York, E. B. Treat & Co. (241-243 West 23d street) 1907. Price $1 50.

In the translators preface we read the following:

The development of bacteriology, since Koch's discovery of the tubercle baeillis in 1881 and the application of solid culture media for the differential growth of bacteria have tended in the last two decades to lead the physician to rely for his diagnosis upon laboratory aids and less upon clinical observation. In order to be thoroughly understood and rationally treated, disease must be studied primarily in its entirety as a pathological process. The physician cannot absolve himself from this responsibility nor find any easy road through the work of another to this desired goal.

The all-absorbing search for the specific cause of a disease, although most valuable when indicated, has too often pushed into the background the manifest clinical evidences of the disease, and the physician has regarded them of subordinate value and apparently even of negligible worth.

The diagnosis of disease must, in the great majority of patients, be determined at the bed-side and not in the laboratory. Laboratory findings are most valuable aids to diagnoses but are not, except in a few instances, diagnoses themsleves and never substitutes for clincal bed-side work.

This present series of monographs accentuates the value of the study of symptoms as observed at the bed-side of the patient and reproduces the marvelous clinical pictures of Trousseau, Niemeyer, Sydenham, Flint and others, illuminated by present-day knowledge of pathology and clinical methods.

Prof. Edmund Neusser, with his rare diagnostic instinct and his almost uncanny memory of clincial facts and their correlation to pathological findings, typifies in the strict sense the modern master clinician.

These lectures are the resultant of almost limitless clinical material and of a scientific acumen which does not overlook any fact no matter how seemingly trivial and unimportant."

It is true that we do need some master of the art of observing to give us a review of the occurrences and possible causation of the more important clinical symptoms, because the latest books on diagnosis have been written rather from the standpoint of organology and patholigical anatomy than from that of the bedside observer. However, the booklet before us is so terse and concise that it is difficult reading. It will not appeal to the average man as such a book should appeal, nor as this book must appeal to the abstruse thinking of a philosopher. It requires more than encyclopedia in formation to make such a work successful.

Surgery, Its Principles and Practice.—Edited by W. W. Keen, M. D., L.

L. D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College. Published by Saunders & Co., in five volumes. Cloth $7, half morocco $8 per volume. Volume II has 920 pages, 572 illustrations and 9 colored plates.

The chapter on diseases of the Bones and Pathology of the chapter on the Surgery of the Joints is contributed by E.H. Nichols, assistant professor of Surgical Pathology at Harvard. The clinical part of the chapter on the Surgery of the Joints is contributed by another Harvard man R. W. Lovett, instructor in Orthopedic Surgery, who also supplies a chapter on Orthopedic Surgery.

D. N. Eisendrath, adjunct professor of Surgery in the University of Illinois, writes two excellent chapters devoted to Fracture and Dislocations.

Only one chapter is given to the Surgery of the Muscles, Tendons and Bursae, but the subject is well taken care of. J. F. Binnie, professor of Surgery of the University of Kansas, writes it.

The Surgery of the Lymphatic System is written by F. H. Gerrish, professor of Surgery in Bowdoin college who gives——pages to the subject.

The Surgery of the Skin is well taken care of by J.A. Fordyce, professor of Dermatology and Syphillogy in the University and Bellevue Hospital Medical Colleges.

The Pathology of the chief Surgical Disorders of the Nervous System is discussed by W. G. Spiller, professor of Neuropathology in the University of Pennsylvania; the Surgery of the Nerves and Spine, by George Woolsey, professor of Anatomy and Clinical Surgery in Cornell; Traumatic Nurasthenia, Hysteria and Insanity, by F. X. Dercum, professor of Nervous and Mental Diseases in Jefferson Medical college; and Surgery of the Insane and Surgery of insanity by J. C. DaCosta, professor of Principles and of Clinical surgery of Jefferson Medical college.

It is of interest to Kansans that one of the most important chapters is written by Professor Binnie of the medical department of our university, who handles the subject in a thorough and definite manner. It is to be noted that the Lymphatic System comes in for a discussion from a surgical standpoint—something that we general practitioners have been looking for for a long time. Again in the treatment of the nervous system from a surgical standpoint, which occupies the last five chapters, find something new and in keeping with the rapid development of the last few years along this line. And the information one gets is clear, definite and practical.

These chapters will certainly interest that part of the profession especially, who are engaged in the state hospitals for the insane. The chapter on fractures occupies only 200 pages, but the information is so concise and definite that the rare and unusual conditions are considered and the common ones not neglected in the least. Not the least valuable part of this chapter is the clear exposition of the very latest and best methods of treatment.

Throughout the whole book the space allotted to pathology and diagnosis is proportioned to treatment in accordance to their relative importance to the practitioner. Altogether this volume keeps up the promise held out by the first of giving the profession the very latest and best surgical information.

Diagnosis and Treatment of Diseases of Women.—By H. S. Crossen, M. D., Clnicial Professor of Gynecology, Washington University, Saint Louis, Mo. Published by the C. V Mosby Book and Publishing Co.

This volume is printed on excellent paper and bound in scarlet and gilt cloth. There are 800 pages and 700 illustrations, 480 of which are from other texts on the subject. The subject matter is presented in a rhetorical style so that one cannot miss the important points presented. Most space is devoted to the diagnosis and treatment of gynecological diseases with only enough of the etiology and pathology to establish the diagnosis. For one who prefers illustrations to solid printed text this book will fill the bill.

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SOCIETY NOTES.

Decatur and Norton County Medical Society. You are earnestly requested to be present. Dr Cole's office; 2:30 p. m., December 10, 1907.

PROGRAM.

1—Annual election of officers.

2—President's address, C. W. Cole.

Paper, C. G. Brethouwer.

3—Cholecyslitis Surgically Considered, H. O. Hardesty.

4—Clinic, General.

Bring in at least one interesting case. A general discussion will follow each paper.

5—Social evening session.

You are expected to be present, and a profitable time is assured.

C. W. Cole, President.

C. S. Kenney, Secretary.

SOCIETY REPORTS.

Hutchinson, Kansas, November 25, 1907.

Editor Journal:—The Reno County Medical Society held its regular monthly meeting in the Commercial club rooms Friday evening, November 22, 1907. There was a good attendance. Dr. F. H. Rose of Stafford and Dr. W. F. Schoor of Hutchinson, were on the program for papers, after which a number of clinical cases were presented and a lively discussion followed, bringing out many interesting and important points in obscure cases.

At the October meeting Dr. C. A. Mann presented a paper on Acute Infectious, Cerebro-Spinal Meningitis. A timely subject which started every member to thinking. At Friday's meeting the members of the society voted unanimously to take up a post graduate course for county societies, every one realizing the benefit derived from harmonious action with frequent and free discussions of important cases. William F. Schoor, Secretary.

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The H. M. C. Compound Anesthetic.

By J. W. NEPTUNE, Salina, Kan.

Men who, like myself, are engaged in the arduous labors of the general practician, rarely have time to sit down and prepare papers for medical journals, to which we can give the research necessary to fit them for a place in the polished medical periodicals of the day. Sometimes, however, there comes before us the question, whether there is the need, not for productions which require an unlimited medical library which will enable us to present a complete monograph on the subject, but where the daily experience of each clinical observer serves to elucidate a point in practice which can only be decided in such a manner.

I, therefore, feel it incumbent upon me to contribute my own clinical observations upon a remedy which seems lately to be exciting a good deal of attention, that is, the H-M-C Compound anesthetic. This remedy has been opposed with unexampled virulence in certain quarters, but seems to be establishing itself in the affections of the profession, since whenever I have attended a meeting of physicians recently there have been some at least who have a word to give in its praise. Having no earthly interest either in favoring it or opposing it, I relate my own experience in its clinical application:

My use of this remedy has been largely in the line of obstetrics.

It has seemed to me to be indicated especially in the first stage of labor, when the os uteri is not yet open, but is somewhat rigid, and the patient is in danger of exhausting herself by efforts to bear down, under circumstances that can only result in her exhausting herself before the time comes when such efforts could be of any avail. Under these circumstances I have been giving of the full strength of H-M-C- compound tablets; and in a few minutes, when the patient has been relieved of the suffering and shows a disposition to sleep between the pains, I usually take my departure, if case is in town, or near my office, feeling quite safe in absenting myself for two or three hours. This one dose is generally sufficient to take the patient through the first stage and up to the beginning of the second; and usually this is the only dose of the tablet which I employ.

About the beginning of the second stage, when the expulsive pains commence, I usually give a little chloroform, generally a mere whiff, just enough to ease the pains and render them bearable. Sometimes the patient is not under its influence more than two to five minutes. To the use of chloroform at this time I attribute my success in preserving the perineum.

I have never noticed any bad effects on the mother from the H-M-C. On one occasion only the child showed cyanosis, recovering after we had worked over it about ten minutes. But this was not more in degree than I have noticed when the H-M-C anesthetic was not used. I have not noticed any special symptoms in the child that could be attributed to the H-M-C. If any prolongation of the labor is to be attributed to the use of this anesthetic, it cannot but be very slight; in fact I cannot say that I have noticed any at all; although possibly when my experience with the anesthetic has extended over several hundred cases I may be able to deduce, as Gauss has said, a little prolongation, about one hour in all. The loss of blood seems to be distinctly reduced. There are no after-pains; the period subsequent to the birth of the child during which these are most likely to occur, being occupied by the patient in a natural and restorative slumber.

I have now used the H-M-C in twenty obstetric cases, and while this number is small I have carefully observed the action of the anesthetic during them, and am satisfied that my conclusions as above recorded are correct.

I have also administered this anesthetic in about half a dozen surgical operations, which have been uniformly favorable. As yet no perilous symptoms or even unpleasant ones have been manifested in any of these cases. I submit this simply as a small personal contribution on this most interesting topic.

COMMUNICATION.

(Resolutions adopted by the Executive Committee of the American National Red Cross, October 18, 1907.)

Whereas, By international agreement in the Treaty of Geneva, 1864, and the revised Treaty of Geneva, 1906, "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross" were adopted to designate the personnel protected by this convention, and

Whereas, The Treaty further provides (Article 23) that "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross can only be used whether in time of peace or war, to protect or designate sanitary formations and establishments, the personnel and material protected by this convention," and

Whereas, The American National Red Cross comes under the regulations of this Treaty, according to Article 10, "Volunteer aid societies, duly recognized and authorized by their respective governments," such recognition and authority having been conferred upon the Amrican National Red Cross in the Charter granted by Congress, January 5, 1905, Sec. 2, "The corporation hereby created is designated as the organization which is authorized to act in matters of relief under said Treaty," and, furthermore,

Whereas, In the Revised Treaty of Geneva, 1906, in Article 27, it is provided that "the signatory powers whose legislation should not now be adequate, engage to take or recommend to their legislatures such measures as may be necessary to prevent the use by private persons or by societies other than those upon which this convention confers the right thereto of the emblem or name of the Red Cross or Geneva Cross."

Be it Resolved, That the Executive Committee of the American National Red Cross requests that all hospitals, health departments and like institutions kindly desist from the use of the Red Cross created for the special purpose mentioned above, and suggests that for it should be substituted some other insignia, such as a green St. Andrew's Cross on a white ground, to be named the "Hospital Cross," and used to designate all hospitals (save such as are under the Medical Departments of the Army and Navy and the authorized volunteer aid society of the government), all health departments and like institutions, and, further

Be it Resolved, That the Executive Committee of the Amer-

ican National Red Cross likewise requests that all individuals or business firms and corporations who employ the Geneva Red Cross for business purposes, kindly desist from such use, gradually withdrawing its employment and substituting some other distinguishing mark.

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The Serum Treatment of Exophthalmic Goitre.

Harriet C. B. Alexander * discusses the subject and reports thirteen cases. Four principal theories of the disease have been advanced: (1) That it is due to disease of the sympathetic nervous system; (2) that the seat of the malady is the medulla oblongata; (3) that it is primarily a disease of the thyreoid gland; and (4) that it is a neurosis.

Modern therapeutic measures have been largely based on the "thyreoid" theory. The results of partial strumectomy indicates that the successful removal of a portion of the thyroeid gland can lead to cure or to definite amelioration of the condition. On the theory that the hyreoid secretion normally neutralizes certain general metabolic poisons in the body, Moebius and others conceived of treating cases of exophthalmic goitre, in which there is presumably an excess of thyreoid secretion in the body, by introducing subcutaneously, or by the mouth, the serum of hyreoidecomized animals. It was hoped that the non-neutralized general metabolic poisons of such animals would nullify the toxic effect of the excessive hyreoid secretion. As to the treatment, experience has shown the great importance of general measures; complete rest for a time, fresh air, careful diet, mild balneotherapy, etc.

The name Thyreoidectin has been given to a preparation obtained under aseptic precautions from the blood of animals from which the thyreoid glands have been removed, and which is exhibited as a redish brown powder contained in capsules, usually five grains each. Carefully conducted clinical trials seem to show that Thyreoidectin can be depended upon to control the characteristic symptoms of exophthalmic goitre. In most cases the patient experiences much relief from the restlessness, tremors, insomnia and other nervous symptoms so frequently present, and a gradual lessening of the frequency of the pulse rate, decrease in the size of the glands, and a diminution of he exophthalmos, with an increase of weight and a much better condition generally. The dose of Thyreoidectin seems to be one or more capsules after each meal, according to the judgment of the physician and the reaction of the patient.

In nine of the author's thirteen cases the size of the gland was materially reduced, and in every case improvement was observed with respect to one or more of the symptoms.

*The American Practitioner and News, August, 1907.

Report of Communication on Arrangements for International Congress on Tuberculosis.

Washington, Nov. 2, 1907.

Progress along all lines connected with the International Congress on Tuberculosis, which is to take place in Washington September 21 to October 12, 1908, was shown by the reports presented at a meeting of the committee of arrangements, held in New York, at the Associated Charities Building, Monday evening, Oct. 28. Dr. Lawrence F. Flick of Philadelphia, chairman of the committee presided, and the other members present were Dr. Joseph Walsh, Philadelphia, secretary; Dr. John S. Fulton, Washington, secretary-general; Mr. William H. Baldwin, Washington, Dr. Herman M. Biggs, New York, Dr. Frank Billings, Chicago, Mr. Edward T. Devine, New York, Mr. Livingston Farrand, New York, Dr. J. C. Greenway, Greenwich, Conn., Dr. Chas. J. Hatfield, Philadelphia, Dr. Abraham Jacobi, New York, Dr. Alfred Meyer, Mrs. James E. Newcomb, New York, Gen. Geo. M. Sternberg, Washington, and Dr. Wm. H. Welch, Baltimore.

The meeting was the first held since Dr. Flick's return from abroad, and his reports of his visits to the International Conference on Tuberculosis in Vienna and to the International Congress on Hygiene and Demography, at Berlin, were interesting features of the session. More than a thousand delegates were registered at Vienna, he said, and the gathering at Berlin was quite as large. The leading men in both associations are looking forward with a great deal of anthusiasm, Dr. Flick said, to the meeting in Washington, next year, and about four hundred of the members of the foreign organizations may be expected to attend the congress. The conference selected this country as its place of meeting in 1908, just as the congress did two years ago. The conference and the congress are two distinct organizations. The international conference on Tuberculosis meets every year and keeps up a continuous organization with headquarters in Berlin. The International Congress on Tuberculosis meets only once in three years and does not maintain an international bureau in the intervals. Dr. Flick stated that at the International Conference, interest centered especially in the time-worn subject of the routes of invasion for the tubercle bacillus. It seems to have been demonstrated that the disease may be contracted by both the respiratory route, and the alimentary route.

Though this does not make us much wiser in a practical way, still it is somewhat comforting to know that the respiratory route is less important than it was once thought to be. On the other hand that information is compensated by the importance of the alimentary route.

In connection with this account of the progress made in the preliminary arrangements for the International Congress on Tuberculosis Dr. John S. Fulton the secretary-general, reported that ten distinguished foreigners have consented to participate in the series of special addresses that are to form a part of the program. The names of these eminent specialists follow:— Dr. R. W. Philip, Edinburgh; Dr. C. Theodore Williams, London; Dr. Arthur Newsholme, health officer, Brighton, England; Dr. C. H. Spronck, Utrecht, Holland; Dr. Karl Turban Davos-Platz, Switzerland; Dr. Gotthold Pannwitz, Charlottenburg; Dr. Emil von Behring, Marburg; Dr. A. Calmette, Pasteur Institute, Lisle, France; Dr. Maurice Letulle, Paris; and Dr. S. Kitasato, Tokyo, Japan.

Dr. Fulton also reported that up to the date of the meeting, the governors of twenty-three states had lent official auspices to the congress. This not only assures official representation so far as that many states are concerned, but it insures an active organization in each of these states, that will be interested in the congress. The states in which this action has been taken so far, are: California, Kansas, Utah, Tennessee, Montana, South Carolina, North Dakota, North Carolina, Minnesota, Maryland, Wisconsin, New York, Illinois, Massachusetts, Iowa, Vermont, Indiana, Maine, Michigan. West Virginia, Ohio, Missouri, Kentucky.

Reporting on the formation of state committees, the secretary-general said that such committees had been appointed in nearly all of the states in the United States; that several have already organized and are earnestly at work. He reported also that replies have been received from various foreign countries in reference to the appointment of committees, and the replies indicate that the countries addressed will be represented in nearly every instance by exhibits as well as by delegates.

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The School and the Street.

From the Medical Review of Reviews.

The day when absolute possession of scientific and technical knowledge was a prerogative of the fraternity of professional men has been relegated to the domain of historical record.

The popularization of such knowledge is the natural sequence of a vast increase in the comprehension of higher education and the universal dissemination of facts through the agency of periodical literature. The school has been supplied with every available means for scientific research and is the great laboratory in which every public need is carefully studied and the results adopted to social requirements. It is a significant fact, however, that the man in the street has, by his financial assistance, cleared the way for the propagation of scholastic attainment far exceeding the possibilities of a quarter of a century ago.

The school has made enormous progress during that period, but the street has advanced even more rapidly.

The progress of medical science has been such as to radically change the relations of the members of the profession to each other and also to the public.

With increased knowledge of the natural history of diseases, together with the methods of prophylaxis and treatment, has developed the duty of the physician to instruct the man in the street upon these vital questions, within reasonable limits.

The medical practitioner cannot now decline to give to the public, through the lay press, professional views on the subject of infectious or otherwise communicable diseases, although formerly (and even now in some instances) it was considered unethical to do so. In the great field of preventive medicine a judicious discussion in the lay press of all subjects pertaining thereto is the only method whereby the co-operation of the public can be successfully enlisted. The only safety in such publicity, however, rests in the instruction of the people on matters which have been definitely settled in the school, in the laboratory, in the clinic. Until everything has been thus tested and proven, the man in the street can only be confused and hindered in his ambition for the protection of his health and life.

APPENDICITIS DURING PREGNANCY.

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Some months ago my attention was drawn to the subject of appendicitis during pregnancy by the following case:

April 17, 1906—Mrs. W., 23 years old, the mother of a healthy 3 year old boy, consulted me because of pain and persistent soreness in the region of the right ovary. She stated that ten days previously she was walking along the street near her home, when she was suddenly attacked with severe pain in the region of pelvis and right ovary, and which was so severe, that she nearly fell to the street. She got home with great difficulty, however, and went immediately to bed. A physician was summoned, who applied an ichthyol vaginal pack and hot fomentations. This caused so great discomfort, that the pack was removed. The pain somewhat subsided, but the tenderness and soreness continued.

An examination ten days after the attack showed very rigid abdominal muscles, and a point of exquisite tenderness low down in the region of the right ovary. By vaginal examination a distinct mass was made out in the right ovarian region, and also the left ovary could be easily felt. It was about the size of a small orange, apparently cystic. There was great tenderness on examination, particularly the right side. The cervix was soft; the uterus enlarged; and the vaginal mucous membrane was dark in color. There had been no morning nausea, but the breasts were enlarged and tender.

A diagnosis of extra-uterine pregnancy was made with probably partial rupture of the gestation sack. Immediate operation was advised.

The following morning under ether anesthesia, Drs. Trexler and Knipe assisting, a median incision was made through the edge or the right rectus muscle. There was no extra-uterine pregnancy. The left ovary was enlarged, and contained a normal cyst of the corpus luteum of pregnancy. The right ovary was enlarged about the size of large walnut, and cystic. This was removed. The appendix was found pointing downward and inward over the brim of the pelvis. It was enlarged and club shaped, and adherent to the right ovary and to the intestines. It had not ruptured and was easily removed. The wound was closed without drainage. Primary union resulted. On the sixth day after operation, the patient aborted. The foetal tissue indicated a pregnancy of about three weeks duration.

This unexpected discovery of an appendicitis associated with pregnancy, brought the question to my mind, that possibly these conditions not infrequently complicate one another. On this point, however, the literature is unusually silent. Many writers on obstetrics and surgery mention appendicitis as a complication, but none, that I have been able to find, mentions its frequency. In order to determine this point in a relative way, I took occasion to write six of our prominent obstetricians and surgeons for their experience in this connection. The result was by no means uniform, or indicative of a definite conclusion. Out of 2000 cases of labor I was unable to find more than ten cases of undoubted appendicitis recorded; and of this number, only 2 were operated on during pregnancy; one at the fourth and one at the fifth month. Both were of the catarrhal type and both recovered.

The experience of the various practitioners consulted was remarkable in its variety. One reported two cases in 250 pregnancies; and another never had seen a case in almost 1000 labors. This great discrepancy comes from the fact that often an appendicitis is mistaken for a right tubal disease; nor is this diagnosis easy. How completely one condition may mask another is demonstrated by my own case herein reported. The character of the practice also may differ widely among individuals;—The general practitioner and obstetrician seeing unquestionably more cases of normal labor than the gynaecologist or surgeon.

In the past few years it was thought that appendicitis was much more common in men than women; but with the increase of our knowledge of the disease and our more accurate methods of diagnosis, statistics on this subject have been markedly changed. In the earlier editions of Deaver's work on appendicitis, he stated that 80% of all cases occured in males; but in the last edition, he very materially modified this opinion. In 3000 cases operated on by himself, there were only about 60% males to nearly 40% females. Einhorn, (quoted by Dr. McRae,) in 18000 successive autopsies found perforating appendicitis in 55% of males and 57% of females. Robinson, (quoted by Deaver,) in 128 autopsies found evidence of past peritonitis, on or about the appendix in 68% women, and in 56% of men. Sounebery found 40% of his cases were in women. Hermes found in 1577 cases of appendicitis in Berlin, 40% were in females. The contention, that this per cent should even be greater in women, seems reasonable, as many cases of abdominal pain in the right iliac fossa are referred to the "tubes and ovaries" often without warrant. This opinion is also supported by the fact brought out by McRae, that in almost all cases in women, the attack of appendicitis occured at or near the menstrual period. In 15 operations for appendicitis in women, he observed 4 cases, over 25%, in which there was also distinct disease of the right tube and ovary.

When we consider that over 61% (61.63% Deaver) of all cases of appendicitis occur between the 20th and 40th year, and that at least 40% occur in women, it seems reasonable to affirm that a large precentage must fall within the period of gestation, and prove a serious complication of pregnancy. More careful diagnosis in the future will, I am confident, demonstrate the truth of this contention.

The mortality of operations for appendicitis, during pregnancy, has been in the past remarkably high. Futh states that out of 42 cases, which he was able to find on record, 22 of the women died,a mortality of 52.3%. He ascribes the gravity of appendicitis during pregnancy "to the displacement of the caecum by enlarging the uterus, bringing the appendix close to the liver or uterus." This is, undoubtedly, a factor in rendering the resulting infection more severe and operative interference more difficult.

Abortion, also, is a most important factor in the mortality. It is particularly likely to occur in all cases of severe inflammation or abscess formation. In Futh's cases, it followed in all but one of the 37 operated upon. He says, "If the tendency to abortion in these cases can be controlled by opium or other measures, it may be possible to save more of the patients with appendicitis during pregnancy."

While these conditions unquestionably influence the mortality; yet, to my mind, the question of delay is the real and vital one that determines the death rate. Why should not a pregnant woman with appendicitis have the same chance of recovery, as her non-pregnant sister,—early operation? I cannot but believe that she should have, and will have, if her case of appendicitis is considered irrespective of her pregnancy. The chance of abortion, after an early operation, is very small indeed; for the operation is then done before any extensive inflammation has involved the uterus, or an abscess has rendered the patient septic. The operative manipulation is very slight in a "clean case" and abortion from the anaesthetic alone very rarely results.

The operative wound in the abdomen will not prove a complication; most certainly not in cases where drainage has not been necessary; and even in those cases that are for a time only partially closed, the danger is slight, when compared with the benefits of certain removal of a real menace to life.

In considering the literature on this subject, and also my own limited experience, I am absolutely convinced, that early operation should be undertaken in cases of appendicitis in the pregnant woman, just as it should be in the non-pregnant state. By so doing, the mortality will not be 50% or more, but will be nearer 5 to 10%, depending solely upon those factors that influence it in the general run of abdominal surgery.

603 Bryant Building.

OPERATIVE INTERVENTION IN ECLAMPSIA

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Operative intervention in eclampsia resolves itself into a very nice calculation of the elements of risk involved. The absorption of toxins threatens the life of the patient, by their continued accumulation. The necessary shock to which *Accouchment force* exposes her incites to convulsion, due to irritation of the nervous system.

No other point in obstetric art is so very dependent on the practitioner's being able to weigh these contrasted dangers at their correct values.

Accouchment force, in the early days of surgical interference, meant a rough and brutal exhibition of the end justifying the means, and consequently, many deaths could be traced directly to the maternal traumatism of the operation itself.

Under modern methods of technique, this becomes less objectionable, and some of the leading teachers abroad and most of our own countrymen now endorse the surgical treatment as rational and conservative.

During the pre-eclamptic state, the symptoms which point to artificial interference are: rapid pulse, generally associated with high arterial tension; gastro-intestinal disturbances; lassitude; headache; decrease of all excretions, either rapidly or more slowly, the class of symptoms to be associated with intoxication through some infective absorption.

We always carry with us three classical prodromes of eclampsia; frontal headache—unilateral, visual disturbances, and epigastric pain.

When we consider that Green's Tables show a maternal mortality in ante-partum eclampsia of 46 and foetal of 69, in intra partum of 25 for each, in postpartum, maternal of 7 per cent, the suggestion is clear that the chances of the eclamptic subject are immeasurably improved, as soon as the uterus is empty.

If, in the face of all medicinal measures, the five eliminative processes are inadequate, so that the index of urea is steadily downward, and the amount of albumin steadily increasing, our duty is plain.

It is rather remarkable that the British school of obstetricians, and such German teachers as Winckel, and among the French, Charpentier, all oppose the emptying of the uterus in pre-eclamptic state, fearing that the irritation, resulting from the dilatation of the cervix, might precipitate the convulsion.

The opinions of such authority must be given their due weight, but American practitioners are usually in favor of the prompt emptying of the uterus. In the second stage of labor, there is practically unanimity, provided full dilatation is first secured. In the pregnant state, and in the first stage of labor,where the undilated cervix offers a complete barrier, the palliative method, when selected, will be followed by foetal death, the maternal mortality being 35 per cent.

As over 90 per cent of cases recover immediately after the uterus is empty, the delivery being accomplished early in the attack, it must be conceded, that the expectant plan, advised to avoid irritating the eclamptic uterus, should be condemned as being timid, irrational, and non-surgical.

When it has been decided that, in a given case, operative treatment is indicated, the choice can be defined as among the following:

1st, Caesarean section.

2nd, Mechanical dilatation of the cervix by any method.

3rd, Duhrssen's multiple incisions, immediately breaking down the barrier of the cervix.

4th, Combination of mechanical dilatation and deep incisions.

Caesarean section in the hands of skilled operators, familiar with the method, and having every hospital facility,gives a maternal mortality of 36 per cent.,—a mortality due to shock, atony, hemorrhage, and auto-infection.

In these limited, select instances, the results compare favorably with the best treatment, not surgical. However, the average physician has neither careful training nor hospital to promise him the brilliant statistics of those who set the pace in making records. His case has the double danger of lack of equipment, and greater chance of infection, being conducted in the home without ideal surgical environment. Moreover, the atonic condition of the uterine muscle, making posssible a fatal hemorrhage, and the irritation of the scar, uterine, as well as abdominal, and that associated with the peritoneal inflammation surrounding the sutures in the uterine wall, predispose to future eclamptic attacks.

The second method,that of mechanical dilatation and delivery, is the favorite in my hands. In two cases, which I have delivered lately, this was the method adopted, and the results were entirely satisfactory. Both patients remain apparently well at present.

The first came on in the sixth month in a patient who had suffered a pregnancy nephritis ten years ago, being delivered at term in eclampsia. In the present pregnancy,as soon as the urine showed a large percentage of albumin, being two grammes to the litre by the Esbach test, a daily urinalysis was made. At six and one-half months, a profuse hem-

orrhage occurred, the patient being blanched from loss of blood, the foetus still viable. Digital examination detected a boggy mass low down in the left side, from which, and the symptoms of bleeding, the diagnosis of left lateral placenta praevia was made. There was no dilatation, and with the hope of carrying the case to the 7th month, in interest of the child, the vagina was packed with gauze, left twenty-four hours and removed. Not a stain appeared, nor did it recur for ten days, when the albumin suddenly disappeared from the sample, foetal heart sounds not discernable, no foetal movement perceptible. Diagnosis of death of the foetus was made. Hemorrhage again set in. A rapid bimanual dilatation under deep anaesthesia was done. The rupture of membranes disclosed a prolapsed cord, pulseless. Version easily followed. The forceps to the after coming head completed the delivery. Shock was severe, and nausea with black bilious vomit kept up for twenty-four hours; urine scanty; albumin increased again for two days. The symptoms improved and the patient made an uneventful recovery.

In this case, the dilatation was somewhat difficult, owing to the unpreparedness of the cervix to give away, but with the anaesthesia in competent hands, complete relaxation gave every opportunity for rapid work which was completed in twenty minutes.

The second case was one which I had delivered after induction of labor, in consultation with the family physician two years ago. Her physician having, in the meantime, taken an official appointment, and being out of the city, she consulted me at his request,

Knowing what had been suffered in the former pregnancy, this was watched with great anxiety. No albumin, no casts, no oedema showed until ten days after term, but a fibroma, the size of a small orange, came to the front with the development of the uterine mass.

The delivery in this case also began with hemorrhage, due to the separation of the membranes from the lower uterine segment, the placenta being normally planted.

The cervix, undilatated, was also, in this case, made to disappear under anaesthesia, and the head engaging with uterine atony, the forceps were applied and a living child born.

In each case, the pulse of the pre-eclamptic state was 120 to 130, and continued for some three days following delivery, except when kept under by exhibition of veratrum viride in dose of 3 to 15 drops.

I mention these cases, being recent, and being at the present on the way to convalescence. In neither were casts found, although albumin was very marked, and the kidney insufficiency alarming, one case only eliminating 8 ounces in 42 hours.

As to the operation of Duhrssen, that of the deep multiple incisions,

I have never adopted this expedient but can readily see why it might become a choice of technique in cases demanding rapid extraction, where the interest of the mother and the child demand hasty interference.

The dilatation by Bossi dilators, and the deep incision to remove at once all barriers of the cervix should be the safeguard in such cases. Bossi dilators render the mangement of the dilatation stage mathematical and rapid. Judiciously used, they are perfectly safe.

The operative treatment in eclampsia where undue haste is used, the attempt being made to drag the foetus through an internal os not fully dilated, is the *bete-noir* of the inexperienced obstetrician. No doubt, many mothers perish from ruptured uterus, because in eclampsia, where the supra vaginal portion is found rigid until the beginning of the labor, the delivery is effected by sheer force rather than by art.

It is on account of the dangers of deep lacerations of the maternal soft structures, that one must wait for dilatation and disappearance of the cervix before attempting *accouchment force*; and during this time, experience proves to me, the great value of veratrum viride as a remedy that does things.

To conclude, intervention is always recommended in intra-partum eclampsia with dilated cervix, in late pregnancy, and in first stage of renal insufficiency with full bounding pulse, albumin 10 or 12 per cent. The choice of method should be rapid dilatation of cervix and then forceps or version to complete delivery. Very rarely the deep incisions of Duhrrsen will be indicated.

Halbertsma's method of the ante-mortem Caesarean section is not endorsed by American teachers except in deformed pelvis or on a moribund mother, the foetal heart being perceptible.

Each case of eclampsia brings its own perils, and each must suggest the time and method of mechanical intervention.

605 Bryant Building

DISEASE TYPES IN SOUTHERN KANSAS.*

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That the climate of Kansas is conducive to long life, and that the majority of people live to a good old age, even to the alloted age of man, three score years and ten, is surely true, for in the Bulletin of the State Board of Health for April we have this statement:

"The simple temperate and rural life of the majority of the people of Kansas, together with the splendid climatic conditions which obtain during the greater part of the year, produce the ideal conditions which make for long life for her people. This fact is reflected in the vital statistics of 1905:

"Of the 9708 deaths whose ages are known, 4069 were over fifty years of age or 41.9%.

"The largest number of deaths occuring between any given periods of ages, was the period between sixty and seventy, which was 1298. Eight people reached the age of 100 and two over 110."

We are fortunate in not having any very large cities to breed and disperse disease germs, and to this we may credit in some degree, the number and effect of a great many diseases. It is also true that we have developed in Kansas, all or nearly all diseases common to the latitude. But that some of the diseases are modified in the number of cases, course and symptomatology, from other climates is also true.

That our climate is healthful can be seen in the report of Assistant Surgeons M. M. Shaner and F. H. Atkins of the U. S. Army made about 1874.

They say:

"It is of great salubrity and dryness. Snow flies rarely, and in small quantities, seldom lying more than a day or two. High winds are common, and frequently gales of alarming force often blow for many hours. During the warm months the direction of the wind is from south and east and this is reversed during the cold weather. Malarial diseases do not originate here; all cases having their origination elsewhere. No scurvy, pneumonia, pleuritis or phthisis, have occured during 1872 and 1873, and but six cases of dysentery were treated in that time. Influenza has also been very rare.

Some will say that that report was made a long time ago, and but few people were then living in southern Kansas.

While that may be true as to the length of time we must remember that the southeastern part was quite thickly settled at that time. But grant the criticism; the report shows the non-existence of certain diseases in this climate until polluted by civilization and the change in the climate due to cultivation of the soil and forestry. If such conditions prevailed

*Abstract of a lecture before the senior class of the school of medicine.

at that time it would surely be just to argue that our climate in and of itself, is beneficial to certain types of diseases, if not preventive or curative.

I know of no disease that is peculiar to this climate and not existing in other parts of our country or of any disease that is more severe or fatal here; but that the same diseases differ in symptomatology is true.

Our climate is changing in many respects;—especially is this true in regard to humidity, and consequently in the older and more cultivated sections and along streams we have pools of stagnant water which develop malaria to some extent. Dr. H. L. Snyder of Winfield, Kansas, informs me, that he demonstrated by microscopical blood examinations, 250 cases of malarial plasmodia in one year. Of course Winfield is near the south line of the state and many of these cases came from Oklahoma. Malaria on the account of change of climate is on the increase and even as far north in the state as where I live, Marion county, about 100 miles from the southern line,mosquitoes are on the increase and now are quite numerous where a few years ago they were seldom seen.

But even under these conditions malaria is the exception and not the rule; excepting a few of the counties along the Oklahoma border and here as said before a great many come from our new sister state.

Summer diseases of children such as entero-colitis, cholera infantum and others are prevalent in Kansas, with fatalities;but our statistics do not show as great a death rate as a great many other localities. In 18 years of practice in Kansas I have seen but two cases of cholera-infantum, one acute case which died in about sixteen hours and the other a complication of ileo-colitis which also died. We do have quite a number of acute indigestions and diorrhoeas from errors in diet, but they respond readily to treatment. I am one who believes that we are advancing in the treatment of diseases and that there is efficiency in medicine and dietetics, but I do not believe that all the results we get in Kanses are due to these things. We have in Kansas a wind, air or atmosphere that is exhilirating and freshening and on account of this free circulation of air,even during our warmest months and hottest days there always is sometime during the twenty-four hours when we can get plenty of sleep. nature's health restorer. We can with impunity expose one of these children to this air even in a draft and in this way produce comfort, rest and sleep to our little patient and thus have the assistance of nature in our treatment.

Not long ago an educated gentleman who moved to Kansas from Indiana on account of the health of his little girl, spoke to me in regard to this. On one of the hottest days we had this summer, when passing my house he stopped and said, "Doctor, I left Marian sleeping peacefully,

on a cot in the draft between two windows with no perspiration or restlessness and she will awaken much rested. That is something we could not do in Indiana."

Again, while we have quite sudden changes in temperature they are not so great as in other states and we do not have that ill effect to deal with. For instance while practicing in Iowa I soon learned that after one of these sudden changes my little patients were always worse and I took the following precautions for overcoming it:

The family were instructed to put up a stove in the sick room and when these sudden changes come on build a fire in the stove and let the temperature drop slowly,and this nature does for us in Kansas.

Dr. Latta of Wichita says,

"Whatever it may be due to—enterocolitis in children is very severe in Southern Kansas and I dread the cases more, case for case, than I do typhoids. I am led to suspect that flies take a much more active part in infecting food and spreading this disease than they are credited with. Wherever there are no screens and swarms of flies around a house I regard these cases with much additional anxiety. With well ventilated and screened upstairs rooms I am sure I get the best results."

Dr. Graves of Dodge City says:

"As to the effect of climate on the diseases of the digestive tract of children I think it is decidedly favorable in southern Kansas. The free circulation of fresh air which is exibited here to a much higher degree than in Illinois and other prairie states east, has a beneficial effect, the value of which can hardly be estimated.

I understand it has been claimed by someone that typhoid fever is different in this climate, from that of the eastern states and Europe or as delineated by authors of those localities.

My experience is that it is different in a great many states, but not so much so that it cannot be diagnosed readily by the description of the various authors. In an extended experience you will see all the variations, types and complications as pictured in text books. In this connection Dr. Latta says,

"I do not believe there is any essential difference in the type of typhoid fever found here and that of other localities, I have found no difficulty in harmonizing the cases I meet, with the cases described by authors working on the Atlantic border.

"I think I have seen all the typhoid characteristics here. And in my own practice or in the practice of those near me, all or nearly all the accidents and complications.

"Many cases of typhoid here are mild, but others are as severe as anything I have seen described by authors. Fatalties I think are becoming less, but this is most likely due to improved modern treatment.

"This improved treatment is also responsible probably for the belief in the changing type of the disease. My own cases have averaged milder during the past fifteen years, than they did during the first eight years, but the treatment has been altogether different.

Dr. George Alexander Gibson of Edinburg,in his Practice of Medicine describes the invasions this way, "The period of incubation of typhoid

fever is by no means settled. It has been stated at as long a period as three weeks and as short as one week." I would like to state here by way of parenthesis that in my own case, knowing when the infection took place, I was eight weeks in coming down. Dr. Latta might say that this was due to the improved mode of treatment, but as this occurred before the time of intestinal antisepsis and the prophylatic treatment was practically nothing it must be classed as a period of invasion. During this time I would have fever two or three days and then feel well for several days, but was able to attend to my studies in medical college all of that time. Gibson further says,

"During this time the patient may or may not feel ill. The invasion is less marked than in any other fever and it is a practical difficulty to ascertain accurately the exact day of the commencement. Moreover the patient may occasionally go about during a considerable time after the symptoms have set in.

"The onset may be marked by feelings of chilliness, with a discomfort and languor and a sense of feverishness more especially at night."

"The temperature is one of the most noteworthy and characteristic symptoms of this period. If an evening rise of 1 to 2° a fall of 1° or less the next morning succeeded by a further rise the next evening to a higher point than the preceding, along with a slight morning remission, so that the fever movement has a somewhat climbing or step like arrangement."

"By the end of the first week the evening temperature may have attained to the height of 102 or 103° or more.

In the second week the phenomena are intensified, temperature has arisen to 104° with slight morning remission.

Dr. Osler says,

"In the regular cases the fever rises gradually for the first 5 or 6 days." "Variation in the normal temperature curve are common. We do not always see the gradual step like ascent in the early stage; the cases do not come under our observation at this time."

"As a rule, the symptoms develop insidiously and thepatient is unable to fix definitely the time at which he began to feel ill." "Chilliness occurs sometimes with the fever of onset."

In Kansas instead of the gradual rise of temperature as described by Gibson and Osler and modified by the latter in the variations and "chills occuring sometimes with fever of onset,"the demon is often ushered in with a chill and you may have your highest temperature the first day or two, which gradually settles down to a regular typhoid course and never again through the course of the disease does the temperature reach the height of the first 24 to 48 hours.

In another type, the first week of observation the temperature may be normal mornings and lead you to think you have malaria to deal with.

We do have in south Kansas typho-malarial fever, that is a double infection as will appear later in the two case reports.

I discharged only a short time ago one of these peculiar cases in

which the highest temperature was on the third day and on every other day variation through the entire course of the disease.

Osler says—"There are cases described in which the chief features of the disease have been present without the existence of fever. They are extremely rare in this country. No instance of the kind has come under my observation. Fisk of Denver has met them."

From the information I have been able to obtain from several physicians this form of the disease is quite frequent in the southern part of the state. They are described to me as beginning suddenly, as before described, fever lasting 3 and 4 days; after that time all the other clinical symptoms of typhoid fever with great prostration extending over a period of 2 or 3 weeks.

I am indebted to Dr. H. L. Snyder of Winfield, for reporting the following:

"I received my education at Jefferson in Philadelphia, where typhoid or enteric fever as they are wont to name it, is endemic. My experience in practice has taught me that we have milder cases as a rule, some of which I wish to write of in detail.

"In three years of practice I have had ten or twelve cases of typhoid fever which I term afebrile typhoid.

"The first case of the kind was my brother, a young man then 21 years of age, having had the usual diseases of childhood, was sick with a chill and fever of 102°; blood examination showed tertain malarial parasites. Temperature went to normal in two days, under quinine and tenderness in abdomen developed, with headache, coated tongue and nose bleed, bronchical cough, rose spots in their successive crops, appetite lost.

"Now the temperature, which is the point I wish to emphasize, never went above 100° F. The stools contained mucous sloughs and at times traces of blood. Convalescence slow with great weakness.

"Another case now under observation, taken sick July 5, 1906, headache, temperature 102° F. which subsided in two days under quinine. Abdominal tenderness, headache bronchial cough, rose spots in their successive crops, with a temperature ranging from 96° F. to 100 4-5° F. on one occasion only. The remainder of the time did not go over 99 4-5° F., stools offensive, sloughs, blood specks blood examination negative after first three days. Saw him last July 29, kept him in bed 10 days more on liquid diet, then allowed him to get up and increased food.

"Three days afterwards I was called again. Temperature 102, pulse 110, headache, pain in abdomen. Next morning temperature normal, next evening temperature rose suddenly from normal at 4 p. m., to 103° at six p. m. remained higher until toward morning then went to normal where it remained.

"Diet rigidly liquid. Three days later passed three ounces of blood by the bowels, with sloughs and mucus, pulse of 56 and poor quality. Now on the 25th day of relapse still passed mucous slough and specks of blood. Temperature 98½ to 98 4-5° F. pulse good from 58 to 84 In three years I have seen two severe cases of typhoid fever; one of which died and the other recovered."

The most insidious, deceitful, disastrous and dangerous disease I know anything about is la grippe. Dr. Latta says,

"Lagrippe is certainly much less fatal in Kansas than in the eastern states. It is probably as infectious here and as widely prevalent as anywhere in a country affording an

equal population, but the fatalties are I think not nearly so great. Grip is however much more prevalent here than is recognized even among physicians. The term 'bad-cold' ought to be eliminated. Nine out of every ten of the so-called 'bad-colds' are infections of grip. Grip always demands care and caution no difference how mild. 'Bad-colds' are treated by both physicians and laymen as insignificant.

"No one would treat a recognized case of grip with the same indifference as they would treat a 'bad-cold' but most of the bad-colds are cases of grip,hence the possibilties of mischief."

Dr. Snyder says that they have had one epidemic in Winfield in two years and that of intestinal form. Following this, weakness was marked.

He says "Whether this epidemic was causative or not I cannot say, but think it was, of a number of cases of appendicitis." I believe that this may be true of the intestinal form,the inflammation of the mucous coat of the appendix not subsiding with that of the intestine. There is no organ or tissue of the body that does not suffer from its effects.

The deceitfulness of the disease consists of this: In our climate after two or three days of a more or less severe attack the patient seems to improve very rapidly and in another day or two, to all appearances and feelings of the patient and judgment of the attending physician, i well. This is the point. Let him exercise and sometimes ever so little as getting out on a chair or walking about his room and you have a relapse that is very dangerous affecting some special organ of the body and you cannot tell where until you have it.

In our part of the state the last two years the most serious complication has been endocarditis, with very sudden deaths others, extending into the chronic form with all the horrors of that disease. A few cases have recovered.

Asthma is not very prevalent in southern Kansas and I have known but one case come to the state that was not cured.

Bronchitis is not as prevalent as in lower and more humid climate. Dr. Latta says, "Some of my friends who have practiced further east (Indiana and Ohio) say that bronchitis is much less prevalent here than there," and that coincides with my experience in north Iowa. But since la grippe has been operating in Kansas we have had more bronchitis and pneumonia than before and the majority of cases a complication or result of grippe.

We also have years when an apparent epidemic of these diseases appears, but those are also the years we have the most la grippe.

Our pneumonia is most always of the bronchial type,especially in the beginning, a pleuro-pneumonia being the exception.

Dr. Dillon of Eureka says of pneumonia:

"Typical lobar pneumonia, in which the patient is seized almost without warning, with a violent chill, cough, sharp pains in the chest, rapid, short painful breathing,

livid countenance, followed by high fever, bloody expectoration and complete hepatization, strictly confined to one or more pulmonary lobes and running such a definite course that you could confidently assure the sufferer, that his fever would be gone in about a week, that type of pneumonia is much more rare here than in the east and north. In my experience acute inflammation of the lungs here is much oftener a broncho-pneumonia less abrupt in its onset, hepatization less solid and complete over affected area, line of demarcation between the inflamed and sound tissue not so distinct, and duration of the disease much more variable and uncertain."

On account of our altitude and dry air the disease, heat or sunstroke, so prevalent in the eastern states is practically unknown. This I again believe is due to the wind or free circulation of air.

Finally I want to give you a remarkable experience,not that I believe diphtheria is less prevalent or fatal here than other places. This experience is wonderful.

Dr. Latta says:

"A word about diphtheria and the rural districts. In certain neighborhoods, at least in Sumner county, diphtheria is practically unknown."

"In 22 years work in north Sumner I saw only one case of diphtheria. I was always watching for it, always dreading it, but it didn't come. Many times I thought I had it but the clinical symptoms and results disproved it. Bacteriological tests were applied only of late years and of course it is open to say I overlooked it, but the man who overlooks diphtheria generally finds it out by the accompanying disasters and these disasters did not occur. The one case I saw come from Illinois and brought the infection with him."

Peabody, Kansas.

SPECIAL ANNOUNCEMENT

OF THE

Advance in the Requirements for Admission to the School of Medicine.

From the beginning of the University, the establishment of a medical school has been contemplated when the conditions were such that it could be done on the same thorough basis that had characterized the foundation of the other schools of the institution. In pursuance of this plan, the medical work of the first two years was organized and put upon a definite basis in 1899. As Lawrence did not furnish sufficient clinical or hospital facilities for the last two years, this was postponed until a suitable opportunity offered itself. This occurred when Dr. Simeon B. Bell, of Rosedale, Kansas, gave the University money and property sufficient to build and equip the necessary laboratories and hospitals, and, by the merging in the University of the Kansas City Medical College, the Medico-chirugical College, and the College of Physicians and Surgeons of Kansas City, making it possible to give the full four-year course for the first time in the college year of 1905-'06.

In the meanwhile the work of the first two years has gradually grown since 1899, in conformity with the advances that medical education is making in this country. The laboratory equipment and library facilities have been increased as fast as the funds became available for such a purpose, until at this time the work is well established and the equipment such that the work can be satisfactorily given.

The new buildings at Rosedale are built to conform with the most advanced requirements of medical instruction. Special laboratories and facilities have been provided for investigation along various lines of medical work, so that it is now felt that the medical instruction given here compares favorably with the other schools of the University and the older medical schools of the country.

In this growth it has been found that, here as elsewhere, this increase in the complexity of the medical course demands an increase in the ability of the student to grasp facts as they are presented to him even from the first. It also requires the more or less complete elimination of certain subjects from the regular medical course.

This advance in medical education has been almost entirely along the lines of more laboratory work and work of greater exactness, while

from the standpoint of instruction it means fewer and fewer lectures and more and more individual instruction and individual effort on the part of the student.

It is realized more and more that, in order to give an effective medical education, the student must have a thorough grounding in the various subjects covered by the general terms of anatomy, physiology, and pathology. These subjects are taught almost entirely in laboratories and by laboratory methods, and, for the student who has never been taught to use his hands and powers of observation, this is so new to him that it is almost the end of the first year before he begins to comprehend what is offered to him.

The student who has had but a high-school education finds the great mass of medical literature in German and French closed to him, and when it is considered how very valuable this is, due to the fostering of laboratories and libraries that are used for research by the governments of those countries, it means a very great loss to him.

The public and the profession,as the country grows older and medical knowledge increases, are both demanding more knowledge and a wider information on the part of the physician. The physician of the future must be a man who is able to do more than treat diseases. He must understand the underlying principles of his profession and be ready to serve the community in which he lives, and perhaps it will be his privilege to serve it most efficiently through that greatest and most actively growing field of applied biological science, viz., preventive medicine.

In recognition of these demands, the officials of the University have decided to raise the requirements for entrance to the medical school to one year of approved college work in September, 1908, and probably will soon increase them to two years of approved college work.

With the requirements thus raised, it will be possible for every student to obtain the bachelor's degree at the end of the first two years of medicine, as is now arranged for in the combined college and medical course, requiring six years for completion. This preliminary college work should be so arranged as to give the broadest bearing on the studies which are to follow in the medical school, i. e., subjects which will enable the prospective student of medicine to work effectively.

These two years of college work should include the following studies, with more or less modification to suit individual needs and the institution in which the student is taking this preliminary course: Two years of work in chemistry, with laboratory work, covering inorganic and organic chemistry well. One year of work in physics, with laboratory work, if possible. At least one year of biology, with laboratory work. This should be zoology or comparative anatomy, if it is possible to devote

but one year to it. All of the English, French and German that the student can obtain. In fact, it is felt that this side of his preparation is of but little less importance than the work in science.

The Dean of the scientific department will be glad to discuss and advise prospective medical students as to their preliminary work, and in this way provide for its being arranged so that the student will be best equipped to do effective work upon his entering the Medical School.

A REQUEST—The physicians of the state, through their interest in medical education, have aided largely in the establishment of a Kansas School of Medicine at the State University. This is now well under way and prospering steadily. Indeed, so large are the classes that some effort is necessary to supply them with dissecting material. This suggests a way in which physicians may send further aid to the School, as many have in part, i. e., by urging the local undertakers to send unclaimed bodies to the School.

In teaching anatomy, one of the most difficult things is to secure early stages in the development of the human body, which are of great interest and invaluable for anatomical and histological research. It is only through the interest and co-operation of many practitioners that a proper teaching collection of this kind can be built up. It is the ambition of the teachers at the State University to give the young people that come to them the largest possible opportunity in the study of medicine. Accordingly, they make an urgent appeal to physicians to send to the embryological laboratory such embryos and early foetuses as may come into their hands. These may be preserved in ten per cent. formalin, a saturated aqueous solution of corrosive sublimate,or thirty-per-cent. alcohol, and shipped by express to the University of Kansas, care of C. E. McClung. To secure proper preservation of material, it should be placed in the fixing fluid as quickly as possible and shipped to the laboratory. It is especially desired to secure embryos of the first month for sectioning, and in order to insure thorough fixation of these the chorion, or outer membrane, should be punctured, care being taken to avoid injury to the embryo. The department will be glad to meet any expenses incurred for preservation or express charges.

University of Kansas

SCHOOL OF MEDICINE.

1. **Scientific Department.** Located at Lawrence with the enjoyment of University life and equipment thereby afforded. Admission, high school diploma. Tuition, $25 per annum. Special course of four years for A. B. with two years credit in medicine. Dr. Merwin T. Sudler, Dean.

2. **Clinical Department.** Located at Kansas City. (The laboratory is at Rosedale, the dispensary at 918 Independence avenue, and the clinics in the City, St. Joseph's, St. Margaret's, Bethany, and Missouri Pacific Hospitals.) Admission, by examination or by certificate from the Scientific Department. Tuition, $100.00 per annum. Dr. George Howard Hoxie, Dean.

3. **Training School for Nurses.** Located at the Eleanor Taylor Bell Memorial Hospital, Rosedale. Course, three years. Admission, high school diploma. Terms, uniforms and books furnished. Miss Pearl L. Laptad, Principal.

For circulars, address

GEORGE O. FOSTER,

Lawrence, Kan.

Supplement to the April, 1907, issue of THE JOURNAL
OF THE KANSAS MEDICAL SOCIETY.

CONSTITUTION

AND

BY-LAWS

OF THE

KANSAS MEDICAL SOCIETY.

AS ADOPTED MAY 5, 1904, AND AS
AMENDED TO JAN. 1, 1907.

CONSTITUTION.

ARTICLE I.—NAME OF THE SOCIETY.

The name and title of this organization shall be the Kansas State Medical Society.

ARTICLE II.—PURPOSES OF THE SOCIETY.

The purpose of this society shall be to federate and bring into one compact organization the entire medical profession of the State of Kansas, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problem of state medicine, so that the profession shall become more capable and honorable within itself and more useful to the public,in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES.

Component societies shall consist of those county medical societies which hold charters from this society.

ARTICLE IV.—COMPOSITION OF THE SOCIETY.

SECTION 1. This society shall consist of members, delegates and guests.

Sec. 2. MEMBERS. The members of this society shall be the members of the component county medical societies.

Sec. 3. DELEGATES. Delegates shall be those members who are elected in accordance with this constitution and bylaws to represent their respective component societies in the house of the delegates of this society.

Sec. 4. GUESTS. Any distinguished physician not a resident of this state, who is a member of his own state Society,may become a guest during any annual session on invitation of the officers of this society, and shall be accorded the privileges of participating in all of the scientific work for that session.

ARTICLE V.—HOUSE OF DELEGATES.

The House of Delegates shall be the legislative and business body of the Society, and shall consist of (1) Delegates elected by the component societies, (2) the Councilors, and (3), ex-officio, the president, secretary and treasurer of this society.

Article VI.—Council.

The Council shall consist of the Councilors, and the President, Secsetary, and Treasurer, ex-officio. Besides its duties mentioned in the bylaws it shall constitute the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

Article VII.—Sections and District Societies.

The House of Delegates may provide for a division of the scientific work of the society into appropriate sections,and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

Article VIII.—Sessions and Meetings.

Section 1. The society shall hold an annual session, during which there shall be held daily general meetings, which shall be open to all registered members, and guests.

Sec. 2. The time and place for holding each annual session shall be fixed by the House of Delegates.

Article IX.—Officers.

Section 1. The officers of this society shall be a President, three Vice-Presidents, a Secretary, a Treasurer, and eight Councilors.

Sec. 2. The officers, except the Councilors, shall be elected annually. The Secretary shall be elected for three years. The President shall appoint the first Councilors, to serve for one year, or until their successors are elected. The terms of the elected Councilors shall be for three years, those first elected serving one, two and three years, as may be arranged. All of these officers shall srerve until their sucessors are elected and installed.

Sec. 3. The officers of this society shall be elected by the House of Delegates on the morning of the last day of the Annual Session, and no person shall be elected to any office who is not in attendance upon that Annual Session, and who has not been a member of the society for the past two years.

Article X—Reciprocity of Members With Other State Societies.

In order to broaden professional fellowship this society is ready to arrange with other State Medical Societies for an interchange of certificates of membership, so that members moving from one state to another may avoid the formality of re-election.

Article XI.—Funds and Expenses.

Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates, but shall not exceed the sum of $2.00 per annum, except on a four-fifths vote of the delegates present. Funds may also be raised by voluntary contributions, from the society's publications, and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the finance committee before action is taken thereon.

Article XII.—Referendum.

Section 1. A general meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Society who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Society a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2. The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum provided in the preceding section, and the result shall be binding on the House of Delegates.

Article XIII.—The Seal.

The society shall have a common seal, with power to break ,change or renew the same at pleasure.

Article XIV.—Amendments.

The House of Delegates may amend any article of this constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session; or that it shall have been recommended by the council and published twice during the year in the journal of the society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS.

CHAPTER I.—MEMBERSHIP.

SECTION 1. The name of a physician on the properly certified roster of members of a component society, which has paid his annual assessment, shall be prima facie evidence of membership in this society.

SEC. 2. Any person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been relieved of such disability.

SEC. 3. Each member in attendance at the annual session shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

CHAPTER II.—ANNUAL AND SPECIAL SESSIONS OF THE SOCIETY.

SECTION 1. The society shall hold an annual session at such time and place as has been fixed at the preceding annual session by the House of Delegates.

SEC. 2. Special meetings of either the Society or the House of Delegates shall be called by the president on petition of twenty delegates or fifty members.

CHAPTER III.—GENERAL MEETINGS.

SECTION 1. All registered members may attend and participate in the proceedings and discussions of the general meetings and of the sections. The general meetings shall be presided over by the president or by one of the vice-presidents, and before them shall be delivered the address of the president and the orations.

SEC. 2. The general meeting may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and the public.

Chapter IV.—House of Delegates.

Section 1. The House of Delegates shall meet on the day before that fixed as the first day of the annual session. It may adjourn from time to time as may be necessary to complete its business; provided, that its hours shall conflict as little as possible with the general meetings. The order of business shall be arranged as a separate section of the program.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 25 members, and one for each major fraction thereof, but each component society which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate.

Sec. 3. Twelve delegates shall constitute a quorum.

Sec.4. It shall, through its officers, council and otherwise, give diligent attenton to and foster the scientific work and spirit of the society and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest.

Sec.5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county of the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Sec. 9. It shall divide the state into Councilor Districts, specifying what counties each district shall include, and, when the best interests of

the society and profession will be promoted thereby organize in each district a medical society,and all members of the component county societies, and no others, shall be members in such district societies. When so organized, from the presidents of such district societies shall be chosen the vice-presidents of this society,and the presidents of the county societies of the distrct shall be the vice-presidents of such district societies.

SEC. 10. It shall have authority to appoint committees for special purposes from among the members of the society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 11. It shall approve all memorials and resolutions issued in the name of the society before the same shall become effective.

CHAPTER V.—ELECTION OF OFFICERS.

SECTION 1. All elections shall be by ballot, and a majority of the vote cast shall be necessary to elect.

SEC. 2. The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the general session.

SEC. 3. Any person known to have solicited votes for or sought any office within the gift of this society shall be ineligible for any office for two years.

CHAPTER VI.—DUTIES OF OFFICERS.

SECTION 1. The president shall preside at all meetings of the society and of the House of Delegates; shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and , as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The vice-presidents shall assist the president in the discharge of his duties. In the event of the president's death, resignation or removal, the Council shall elect one of the vice-president to succeed him.

SEC. 3. The treasurer shall give bond in the sum of $1,000. He shall demand and receive all the funds of due the society, together witn

bequests and donations,. He shall pay money out of the treasury only on a written order of the president, countersigned by the secretary; shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be ex officio secretary of the council. He shall be custodian of all record books and papers belonging to the society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall,with the co-operation of the secretaries of the component societies, keep a card-index register of all the legal practitoners of the state by counties, noting on each his status in relation to his county society, and, on request, shall transmit a copy of this list to the American Medical Association. He shall aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this society. He shall conduct the official correspondence, notifying members of meetings, officers of their election, committes of their appointment and duties. He shall employ such assistants as may be ordered by the House of Delegates, and shall make an annual report to the House of Delegates. He shall supply each component society with the necessary blanks for making their annual reports shall keep an account with the component societies, charging against each society its assessment, collect the same, and at once turn it over to the treasurer. Acting with the Committee on Scientific Work, he shall prepare and issue all programs. The amount of his salary shall be fixed by the House of Delegates. His bond shall be for the sum of five hundred dollars.

CHAPTER VII.—COUNCIL.

SECTION 1. The Council shall meet on the day preceding the annual session, and daily during the session, and at such other times as necessity may require, subject to the call of the chairman, or on petition of three Councilors. It shall meet on the last day of the annual session of the society to organize and outline work for the ensuing year. It shall elect a chairman and a clerk, who, in the absence of the secretary of the society, shall keep a record of its proceedings. It shall,through its chairman, make an annual report to the House of Delegates.

SEC. 2. Each Councilor shall be organizer, peace maker and censor for his district. He shall visit the counties in his district at least once year for the purpose of organizing component societies where none exists; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the House of Delegates on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the society.

SEC. 3. The Council shall be the board of censors of the society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

SEC. 4. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 5. The Councilors shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the treasurer of the society. As the Finance committee it shall annually audit the account of the treasurer and secretary and other agents of the society, and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the society during the year and the amount of all other property belonging to the society under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of the secretary, or the treasurer, the Council shall fill the vacancy until the next annual election.

Chapter VIII.—Committees.

Section 1. The standing committees shall be as follows:

A Committee on Scientific Work.

A Committee on Public Policy and Legislation.

A Committee on Arrangements and such other committees as may be necessary. Such Committees shall be elected by the House of Delegates, unless otherwise provided.

Sec. 2. The Committee on Scientific Work shall consist of three members, of which the secretary shall be one, and shall determine the character and scope of the scientific proceedings of the society for each session, subject to the instructions of the House of Delegates. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussion and other business shall be presented.

Sec. 3. The Committee on Public Policy and Legislation shall consist of three members and the president and secretary,. Under the direction of the House of Delegates it shall represent the society in securing and enforcing legislation in the interest of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional iinfluence so as to promote the general good of the community in local, state and national affairs and elections.

Sec. 4. The Committee of Arrangements shall be appointed by the component society in which the annual session is to be held. It shall provide suitable accommodations for the meeting places of the Society and of the House of Delegates, and of their respective committes, and shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the secretary for publication in the program, and shall make additional announcements during the session as occasion may require.

Chapter IX.—County Societies.

Section 1. All county societies now in affiliation with this society or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application, receive a charter from and become component parts of this society.

SEC. 2. As rapidly as can be done after the adoption of this constitution and By-Laws, a medical society shall be organized in every county in the state in which no component society exists, and a charter shall be issued thereto.

SEC. 3. Charters shall be issued only on approval of the Council and shall be signed by the president and secretary of this society. On the recommendation of the Council, the House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

SEC. 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Society and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to any exclusive system of medicine, shall be eligible to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

SEC. 6. Any physician who may feel aggrieved by the action of the society of his county, in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

SEC. 7. In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

SEC. 8. When a member in good standing in a component society moves to another county in this state, his name on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

SEC. 9. A physician living on or near a county line may hold his membership in that conuty most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

SEC. 10. Each component society shall have general direc ion of the affairs of the profession in this county and its influence shall be constantly exerted for bettering the scientific, moral and materia! condition of every physician in the county, and systemátic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

SEC. 11. At some meeting in advance of the Annual Session of this Society, each county society shall elect delegate or delegates to represent it in the House of Delegates of this society in the proportion of one delegate to each twenty-five members or fraction thereof, and the secretary of the society shall send a list of such delegates to the secretary of his society at least ten days before the annual session.

SEC. 12. The secretary of each component society shall keep a roster of its members, and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

SEC. 13. The secretary of each component society shall forward its assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county to the secretary of this society each year thirty days before the annual session.

SEC. 14. Any county society which fails to pay its assessment, or make the report required, on or before the first day of April, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any business or proceedings of tne Society of the House of Delegates until such requirements have been met.

CHAPTER X.—MISCELLANEOUS.

SECTION 1. No address or paper before the society, except those of the president and orators shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any subjcet except by unanimous consent.

SEC. 2. All papers read before the society or any of the sections shall become its property. Each paper shall be deposited with the secretary when read.

SEC. 3. The deliberations of this society shall be governed by parliamentary usage as contained in Roberts' Rules of Order, when not in conflict with this Constitution and By-Laws.

SEC. 4. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XI.—AMENDMENTS.

These By-Laws may be amended at any annual session by a majority vote of all the delegates present at that session, after the amendment has lain on the table for one day.

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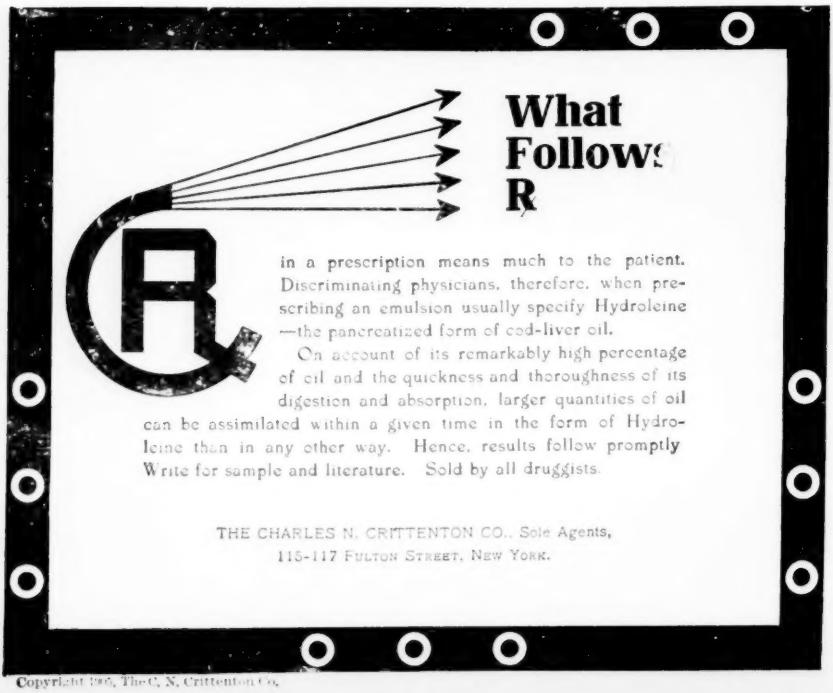
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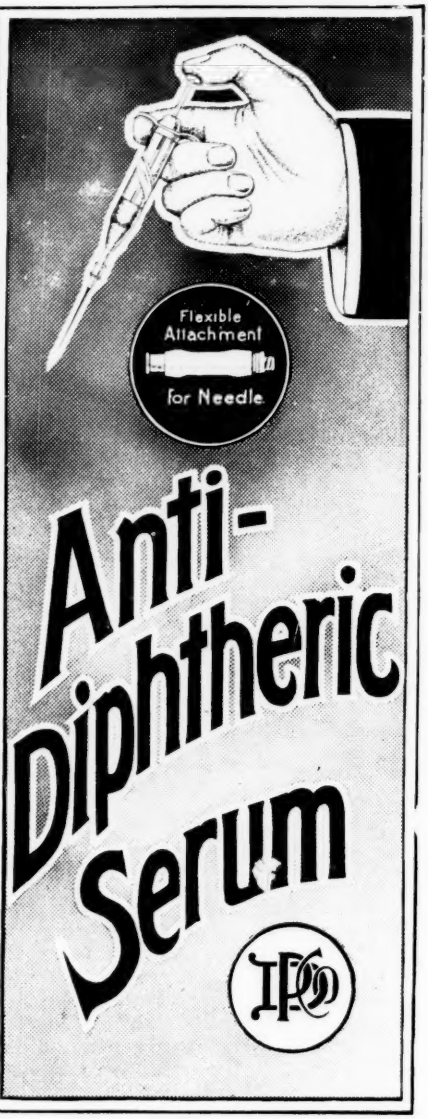

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